CHAPTER IV-ALLOWABLE SERVICES

4.01 Introduction

In addition to those services available under Wisconsin's Medicaid State Plan, the services described in this chapter are reimbursable under the Medicaid Waiver programs covered by the manual. While CIP 1A, CIP 1B and BIW offer the same services, the CLTS Waiver Programs offer a different package of services. There are also two services, Children's Foster Care and Day Services for Children (childcare) that differ in CLTS depending on the target population served. The table preceding Section 4.10 lists the services covered by the various Waivers and shows the two CLTS services that differ by target group.

While the types of services covered under the various Medicaid Waiver programs are similar, some variation is present. The Waiver programs are dependent on federal approval of individual Waiver applications submitted at different times so the approved Waivers differ. While the Department, Division and BDDS strive for consistency among service definitions in the various Waivers, federal discretion at the time of each review has an impact on the definition and even the coverage of allowable services.

4.02 County Role in Ensuring Providers are Qualified

County agencies are responsible for ensuring that all providers used for the provision of a covered Waiver service meet the standards established in this chapter for the specific service for which they claim payment and provide. Counties must create and maintain documentation that verifies that the provider meets these standards by the presence of a license, if applicable, or by documentation that the specific standard for the service is met. Counties must also periodically review providers of covered services to determine that they continue to meet standards.

4.03 Choice of Available, Qualified Provider

All Medicaid Waiver participants must be given a choice of qualified providers of services. The participant or guardian may also select a prospective provider and seek to have the county determine if this provider is qualified according to the standards for providers of the particular covered service.

County agencies can establish a county-wide rate based on an actual bid or estimate they receive from a qualified provider. The rate must be based on specific definitions of the services to be provided. The definitions must include the amount and frequency of services, describe the types of services offered, describe the qualifications of the staff providing the various services and describe any other features that may affect comparisons of the costs of different providers. This rate may apply only to the number of possible Waiver participants the lower cost provider is capable of serving. If the strategy of establishing a minimum rate is employed, the county must have solicited bids from all providers doing business in the county or who expressed an interest

in so doing. Counties may not limit the pool of qualified providers by offering an exclusive agency contract to a provider even if that provider presents the lowest cost alternative.

If a Waiver participant wishes to select a different provider, the other provider must be given the opportunity to reduce their rates or service mix to meet the county-wide rate. Under no circumstances may the adjusted level of services prevent the provider from assuring the health or safety of the participant.

The standards for qualified providers established by the Department and Medicaid Waiver regulations can be supplemented with standards established by the county. Once a county has determined minimum standards for providers, the county may solicit requests for proposals (RFP) from all available and qualified providers. A contract with provider agencies cannot eliminate the participation of other providers. However, a contract can be established that offers a provider priority whenever a participant has no preference and permits all qualified providers to provide service as long as the service is provided at a cost which is equal to or less than the rate the county has established through the RFP process. Counties may establish a higher threshold (such as 105% of the lowest provider) at their discretion. Such a higher threshold is encouraged as a means of supporting choice of provider but is not required.

4.04 Avoiding or Minimizing Conflict of Interest

A. Conflicts of Interest; Definition and Policy

Conflicts of interest as defined in this section must be avoided. If they can't be avoided, the county must take actions to minimize their effect(s). Such conflicts occur whenever a county staff person or a provider has an interest in a particular decision, outcome or expenditure. The interest referred to here is most often one where the situation places the county or provider in an advantageous position that can be financially beneficial. The conflicts covered by this section include:

1. Same Entity is Support and Service Coordinator and Service Provider

   Conflicts that occur when a Support and Service Coordinator or Care Manager is employed by an agency that also provides other services to Waiver participants potentially gives that agency an advantage. In this instance the Support and Service Coordinator may be advising the Waiver participant of alternate service provider options as well as monitoring his/her level of satisfaction with the services provided by the Support and Service Coordinator's own employer. Likewise, the county may be the provider of both vocational and support and service coordination. The Support and Service Coordinators are involved in referring participants to the vocational services provided by their employer. If the same agency is involved in both roles, the difficulties that might arise are that the objectivity of the service selection decisions would be viewed as being

compromised. In each of these situations, the Waiver participant may be steered to the provider unit of that same agency. Even if this does not happen, the appearance of conflict is present.

2. Assisting Participants in Money Management and Receiving Funds

Conflicts can arise if county or provider staff manage participant funds and also make decisions that result in their receipt of participant funds. Any time the same entity benefits from its own decisions, an actual conflict or the appearance of conflict is present.

B. Methods to Address Conflicts of Interest

Counties, Support and Service Coordinators and providers shall avoid or minimize the conflicts of interest listed in A. above by taking one of the following actions:

1. The county can adopt and must enforce a policy that bars Support and Service Coordinators from being employed by any agency that also provides any other services to a Waiver participant served by that coordinator. The written policy and a description of the enforcement method shall be available to representatives of the Department.

2. The county can adopt and must enforce a policy that bars its agents and providers from directly assisting participants in the management of their own personal funds if these same individuals routinely expect to receive any participant's funds for any reason. If this situation occurs, the county shall employ a person or agency to provide financial management assistance for affected Waiver participants. The person or agency providing this assistance or managing the participant's funds shall not receive any of the participant's funds they manage. The written policy and a description of the enforcement method shall be available to the Department on request.

3. If one of the conflicts described in A. of this section is present, and the county cannot eliminate it using one of the methods described in this section, the county may develop and submit a plan to their assigned CIS. This plan shall include:

   a. A description of the conflict on interest,

   b. An explanation of why the methods described in 1 and/or 2 of this section cannot be used in this situation,

   c. A plan for how they intend to reduce the possible adverse effects of the conflict.

      - For conflicts involving the same entity providing both Support and Service Coordination or Care Management and a Waiver-covered service, this description must address how the county will deal with the scenario of a participant requesting a change of provider.

- For conflicts involving management and receipt of participant funds, the plan must clearly describe any use of participant funds that involves a payment to the county or any of its agents or providers and provide a reason for this payment.

C. Criteria and Considerations for Approval of Conflict of Interest Plans

These plans, if chosen as the county's preferred method of addressing the conflict, are both subject to approval by the Department based on the efficacy of the approach the county proposes to avoid or minimize the conflict. Plans should demonstrate a high degree of organizational separation and autonomous decision-making among Support and Service Coordinator/ Care Managers and other service providers working with participants while employed by the same agency.

Plans are not required and a conflict does not exist if a county is "leasing" the support and Service Coordinators or Care Managers from the agency that also serves as a service provider. Here it is assumed that supervision and direction of these staff come from outside the provider agency. Approval of plans addressing the conflicts involving the same employer will be based on the following considerations:

1. That the county describes reasonable and effective efforts it has made to secure more than one provider of the services affected by this conflict;

2. That the county has counseled the participant and the guardian on the choices of providers both verbally and in writing and obtains a signed acknowledgement that the choices have been explained to them;

3. The agency has taken adequate steps to reduce or eliminate potential for conflict of interest within the agency. This may include such steps as using different supervisors for the staff involved in the conflict; and

4. The plan describes continuing efforts the county will make to try to eliminate the conflict by separating Support and Service Coordination or Care Management from service provision.

5. The use of Support and Service Coordinators or Care Managers as providers of financial assistance may be approved only when the county convincingly demonstrates that the alternatives to this are not feasible. Approval of plans addressing the financial conflicts will be based on the following considerations:

   a. All potential payees including family members, close friends or independent agencies were contacted but none was willing/able to fill the role.

   b. The choice of other providers was offered or no additional were available in the geographic area.

c. County staff or its agents, Support and Service Coordinators and providers proposed to be involved in providing financial assistance have assured participants that he/she has informed choice regarding the selection of a representative payee or fiscal intermediary to provide this service.

d. Documentation is provided indicating that the participant and the guardian were informed that the choices described in1 and 2 above can and will be offered in the future.

e. The agency has taken adequate steps to reduce or eliminate potential for conflict of interest within the agency.

f. The county must agree to not accept any contribution of funds made by the Waiver participant.

4.05 General Provider Screening Requirements

Caregiver background checks are required for service providers whose services are funded by the Medicaid Waiver programs. Caregivers include anyone who meets the statutory definition of caregiver under S. 50.065 Wi. Stats. This definition include "…those persons who will have "regular, direct contact with clients." "Regular" means "contact that is scheduled, planned, expected, or otherwise periodic." "Direct contact" means "face-to-face physical proximity to a client that affords the opportunity to commit abuse or neglect… or to misappropriate the property of a client."

Examples of persons who meet the definition of caregiver may include supportive home care workers providing home care, respite care providers, people who perform home chores inside the home under supportive home care, adult family home providers and others. Supportive home care providers who provide outside chores including lawn mowing or snow removal do not meet the definition of a caregiver and are therefore not covered by this requirement. Certain other caregivers are also exempt from this requirement. See the service specific definition in section 4.10 of this chapter for exempted caregivers or service providers.

Required background checks include:

1. A criminal history search from the records of the Wisconsin Department of Justice, and

2. A search of the Caregiver Registry maintained by the Department of Health and Family Services, and

3. A search for the status of credentials and licensing from the records of the Wisconsin Department of Regulation and Licensing, if applicable.

County Waiver agencies must ensure that those persons employed as caregivers by the county agency, as well as those employed as caregivers by any agency contracted to provide Medicaid Waiver funded services have had the background checks completed. Waiver program agencies **may not** employ any person who has a criminal conviction substantially related to the care and safety of agency clients. Agencies **may not** employ persons listed on the Caregiver Registry due to a finding of misconduct. Agencies **may not** employ persons denied license, certification or registration or denied renewal of license, certification or registration due to a finding of misconduct. Agencies must establish a process to allow such persons to seek a Rehabilitation Review as described in HFS 12.12.

The requirement for caregiver background checks applies to any person (including a relative) who meets the definition of a caregiver and whose services are to be funded by the Medicaid Waiver programs. The requirement for background checks does not apply to volunteers or other persons providing services to Waiver program participants whose services are not funded by a Waiver program. These background checks must be repeated every four years.

Note: County agencies may adopt policies that are more restrictive than these requirements. Any such requirements must be uniformly enforced and may not be used as a means of restricting choice of provider.

4.06 General Provider Limitations

A. Limitations on Payments to Spouses or Parents of Minor Children

Services provided by the spouse of a Waiver participant or the parent of a minor child who is a Waiver participant cannot be reimbursed by Medicaid Waiver funds. However, county Waiver agencies may choose to reimburse those persons for services provided to Waiver participants using other funding sources.

B. Requirement to Use Medicaid State Plan-Covered Services

With the exceptions of Support and Service Coordination, the participant must utilize services covered by the Medicaid State Plan to the fullest possible extent before using services covered by the Waiver. For example, a participant requires 40 hours of personal care per month. Medicaid representatives authorize 30 hours per month, the remaining 10 hours may then be reimbursed with Waiver funds.

C. No Cash Payments to Participants

Under no circumstances can cash payments ever be made directly to a Medicaid Waiver participant or any other representative of the participant except for fiscal intermediaries under Financial Management Services (SPC 619). All payments for Medicaid covered Waiver services must be made directly to the provider of service.

D. No Payments for Services in a Hospital, Nursing Home or ICF/MR

Generally no payment can be made for services delivered in a hospital, nursing home or ICF/MR unless the payment is for institutional respite. A person-specific variance approved by the Department is required in order to fund institutional respite in these settings. See Chapter VI Section 6.10 for details that describe special circumstances.

E. Support and Service Coordination

Except for situations when a Waiver participant is receiving CSP, Support and Service Coordination for Waiver participants shall not be billed to the Medicaid State Plan.

4.07 Reserved for future use.

4. 08 Service Definitions for CIP 1A, CIP 1B, BIW and CLTS

LISTING OF COVERED SERVICES BY CIP 1A, CIP 1B and BI WAIVERS				
SERVICE CODE(SPC)	**SERVICE NAME**	**CIP 1A/B & BIW**	**CLTS (see Section 4)**	**Page Number**
112.57 112.99	**Adaptive Aids-Vehicle Related Adaptive Aids- Other**	Yes	Yes	10
102	**Adult Day Care**	Yes	No	12
202.01	**Adult Family Home- 1-2 bed**	Yes	No	14
202.02	**Adult Family Home 3-4 bed**	Yes	No	16
203	**Children's Foster Care/ Treatment Foster Care Developmental Disabilities[1]**	Yes	Yes	18
203	**Children's Foster Care/ Treatment Foster Care - Mental Health**	Yes	Yes	22
203	**Children's Foster Care/ Treatment Foster Care - Physical Disabilities**	Yes	Yes	25
112.47	**Communication Aids**	Yes	Yes	28
506.61	**Community Based Residential Facility**	Yes	No	30
609.10	**Consumer-Directed Supports**	Yes	No	31
609.20	**Consumer and Family-Directed Supports**	No	Yes	34
113	**Consumer Education and Training**	Yes	Yes	37
507.03	**Counseling and Therapeutic Services**	Yes	Yes	39

[1] Same definition for CLTS as for CIP 1 and BI Waivers.

110	**Daily Living Skills Training**	Yes	Yes	41
706.10	**Day Services-Adults**	Yes	No	43
706.20	**Day Services-Children (Developmental Disabilities)**	Yes	Yes	45
706.20	**Day Services-Children (Mental; Health)**	No	Yes	49
706.20	**Day Services-Children (Physical Disabilities)**	No	Yes	52
619	**Financial Management Services**	Yes	Yes	55
402	**Home-Delivered Meals**	Yes	No	57
112.56	**Home Modifications**	Yes	Yes	59
610	**Housing Counseling**	Yes	No	63
106.03	**Housing Start-up**	Yes	No	65
512	**Intensive In-home Autism Services**	No	Yes	67
710	**Nursing Services**	Yes	No	72
112.46	**Personal Emergency Response System (PERS)**	Yes	No	**74**
108	**Pre-vocational Services**	Yes	No	75
103.22 **103.24** **103.26** **103.99**	**RESPITE CARE:** **Residential** **Institutional** **Home-based** **Other Respite**	Yes	Yes	80
112.55	**Special Medical and Therapeutic Supplies**	Yes	Yes	83

107.30 **107.40**	**Specialized Transportation- 1 way trips** **Miles**	Yes	Yes	85
604	**Support and Service Coordination** (formerly case management)	Yes	Yes	87
615	**Supported Employment**	Yes	Yes	93
104.10 **104.20**	**Supportive Home Care- Days** **Hours**	Yes	Yes	98

ADAPTIVE AIDS

112.57 Adaptive aids- Vehicles
112.99 Adaptive Aids Other

DEFINITION

Adaptive Aids are devices, controls or appliances which enable persons to increase or maintain their abilities to perform activities of daily living, participate in typical home and community activities, control their environment and prevent institutionalization. Adaptive aids facilitate self-reliance and independence and community participation may decrease the need for paid care and may reduce the risk of institutionalization. Adaptive aids consist of any device that achieves any of the objectives specified in this definition. The following list illustrates the kinds of items and services that may be included under this service. This list is not all-inclusive but is intended to illustrate the items and related services that may be purchased under this service.

1. Lifts including van lifts under vehicle related adaptive aids, lifting devises and standing boards/frames/wheelchairs;
2. Control switches, pneumatic switches and devices including sip and puff controls;
3. Environmental control units including locks, electronic control units and safety restraints;
4. Prosthetic devices that enable the participant to perform typical community activities independently;
5. Devices that accommodate sensory deficits including magnifiers or devices to assist the participant to read or see, trained or certified animal assistance, such as canines for people with visual or physical impairments;
6. Computers and computer software; and
7. The cost of services needed to install, maintain or repair the covered device.

To permit the efficient response to rapid changes in technology, new devices or technologies not included on the list but which accomplish the purpose and objective of this service are to be covered by the Waiver if the need is assessed.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Includes only Adaptive Aids that are either not covered or that cannot be obtained under Wisconsin's Medicaid State Plan.

2. Adaptive Aids that are covered but are denied funding for the specific participant under the Medicaid state plan are covered by the Waiver if the person’s assessment establishes the need for the item.

3. All items costing in excess of $1000 require documentation from a rehabilitation organization or Occupational or Physical Therapist that the purchase is appropriate to the participant served. The cost of the evaluation to determine the appropriateness of the Adaptive Aid is an allowable expenditure under this service.

4. Includes the cost of installation, maintenance and repair of an approved adaptive aid even if the item was not purchased under the Waiver program so long as the person has a continuing need for the item.

5. A Waiver participant may receive only one computer as an approved adaptive aid or as a covered item under any other covered Waiver service. This does not include replacement computers, upgrades or new programs which can be purchased when the computer the Waiver participant has is either not functioning, cannot be repaired cost effectively or is obsolete.

STANDARDS

1. Adaptive Aids must meet Underwriter's Laboratory and/or Federal Communications Commission requirements where applicable for design, safety and utility.

2. Adaptive Aids should, when appropriate, be obtained from authorized dealers of the product, typically medical supply businesses or organizations that specialize in the design of adaptive equipment. Best practice suggests that to ensure participant safety, competent installers who can provide documentation of their professional training and experience should be selected to install Adaptive Aids.

DOCUMENTATION

1. For items that cost in excess of $1000, there must be written documentation from a rehabilitation organization, a physical therapist or an occupational therapist, indicating that the purchase is appropriate to the participant's need.

2. The file must contain documentation that the adaptive aid has been denied by or cannot be obtained through Wisconsin’s Medicaid State Plan.

3. There must be documentation that the item purchased is appropriate to the participant’s needs.

4. When the adaptive aid includes a computer, the ISP shall state that the computer purchased shall be used for any other covered service that includes the use of a computer. Other services, if any, for which a computer is being used shall be identified in the ISP.

ADULT DAY CARE

SPC 102

DEFINITION

Adult Day Care consists of the provision of services for part of a day in a group setting to adults who need an enriched social or health-supportive experience or who need assistance with activities of daily living, supervision and/or protection. Adult Day Care gives older people with a developmental disability and/or brain injury an opportunity to share this experience with their peers. Services include personal care and supervision, provision of meals, provision of medical care, transportation to and from the day care site unless provided as part of the Specialized Transportation and programming and activities designed to meet the physical, social, emotional, health maintenance or restorative and leisure time needs. Also includes coordination of recipient services and regulation/certification activities. Adult Day Care may be provided in family homes, freestanding centers and multi-use facilities such as churches, schools, and senior centers.

Adult day care is categorized as follows:

1. Adult Day Care Center. Care which is provided for part of a day (e.g., less than 24 hours) in a group facility for adults.

2. Family Adult Day Care. Care provided for part of a day for small groups of no more than 6 adults in the home of a provider.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Waiver funding is not available for Adult Day Care provided in a nursing home or on the grounds of a nursing home unless a variance is granted by the Department. Variances should be submitted in writing with the person's ISP and apply only to the person who is the subject of the request and to the specific provider. Variances are not transferable. The request for the variance must explain why a provider outside of an institution is not available and used for each participant.

2. Provider Screening Requirements: All persons who provide this service shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of these services such as misappropriation of participant funds shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

3. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9.

STANDARDS

Adult Day Care must be provided in a state certified facility. Providers of services are governed by the certification standards for Adult Day Care issued by the Department of Health and Family Services, Division of Disability and Elder Services, effective June 7, 1996 and issued with DCS Memo 96-13 (DCS became DSL and is now DDES).

DOCUMENTATION

1. The provider must have evidence of current certification.

2. For billing purposes, the provider must be able to produce documentation such as attendance records to verify the units of service billed to the Waiver program.

3. There shall be documentation of current and up to date criminal and caregiver background checks in the participant's or a provider file on all persons providing services and supports to any Waiver participant.

ADULT FAMILY HOME

SPC 202.01: 1-2 Beds

DEFINITION

A private residence in which support and services above the level of room and board are provided to one or two people. The person or persons who provide the support and services typically reside in the residence and make the residence their primary domicile. May also include a residence controlled by a third party including a corporation where a person or persons who provide services live-in and share the residence with the people receiving the support and services. In this situation, the care-giver's occupancy is conditioned on their providing services to the persons receiving the support and services. May also include a private residence where staff come to the residence to work specific shifts and typically do not stay over night. In these homes, the provider does not make the place their primary domicile.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. All Adult Family Homes for one or two persons shall be certified pursuant to the standards in this section and in the Medicaid Waivers Manual. The certification shall specify the number of beds that can be used to serve Waiver participants or others who the provider serves.

2. Transportation services may be provided by the sponsor of the home or the sponsor's agent. The cost of the transportation included in this service may not also be included under SPC 107, Specialized Transportation.

3. Provider Screening Requirements: All persons providing this service shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

4. The sponsor and all persons working in the home must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9.

5. County support and service coordinators or staff responsible for the certification of 1-2 bed adult family homes shall report any of the following actions to a CIS assigned to that county:

    1) refusal to accept an application for certification,
    2) denials of original certification,
    3) denial of recertification of a current adult family home,

4) approval of an applicant who had been previously denied certification or who had their certification revoked for any reason after the two year waiting period, the removal of any person providing services in the home for any reason that has anything to do with the person's qualifications to provide services or ability to assure the health or safety of a resident, any exception to the standards granted under the authority of MA-W- 03 (5), any special conditions of approval of certification and the results of any review resulting from an appeal from any applicant or provider of this service.

STANDARDS

1. All 1-2 Bed Adult Family Homes must be certified according to the standards entitled Certification Standards for 1-2 Bed Adult Family Homes. These standards are contained in the Appendix of the Medicaid Waivers Manual.

2. If the sponsor or other person providing services in and for the adult family home provider also provides transportation services, they shall meet the provider requirements of SPC 107, Specialized Transportation.

DOCUMENTATION

1. All providers of Adult Family Home care must have evidence of valid certification for a number of beds that is not less than the number of people served.

2. There shall be documentation of current and up to date criminal and caregiver background checks in the participant's or a provider file on all persons providing services and supports to any Waiver participant.

ADULT FAMILY HOME

SPC 202.02 3-4 Beds

DEFINITION

A private residence in which support and services above the level of room and board are provided to three or four people. The person or persons who provide the support and services typically reside in the residence and make the residence their primary domicile. May also include a residence controlled by a third party including a corporation where a person or persons who provide services live-in and share the residence with the people receiving the support and services. In this situation, the care-giver's occupancy is conditioned on their providing services to the persons receiving the support and services. May also include a private residence where staff comes to the residence to work specific shifts and typically do not stay over night. In these homes, the provider does not make the place their primary domicile.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Adult Family Homes for 3-4 individuals must conform to the definition contained in S. 50.01 (1) Wi. Stats., either HFS 88 or HFS 82 standards in the Wisconsin Administrative Code and be licensed by the state Bureau of Quality Assurance or other approved licensing agency.

2. Transportation services may be provided by the sponsor of the home or an agent of the sponsor. If the cost of the transportation is included in reimbursements for this service, it may not be separately included under SPC 107, Specialized Transportation.

3. The sponsor of the home and all persons providing services and supports shall be subject to criminal and caregiver background check before they begin employment. Both of these background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. HFS 88 and HFS 82 Rules provide the provider screening requirements for these providers.

4. All providers including substitute providers must communicate with designated county staff and other providers within confidentiality laws any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9.

STANDARDS

Providers must comply with and be licensed pursuant to HFS 88 or HFS 82 standards for 3-4 bed Adult Family Home used by Waiver participants.

DOCUMENTATION

1. Evidence of a current, valid license for each person who provides this service shall be available on request and shall be maintained in either each participant's county file or in a provider file.

2. Documentation of current caregiver and criminal background checks of all persons providing care in the home including substitute providers must be available and easily accessed upon request. This documentation may be in either each participant's county file or the county's provider files.

CHILDREN'S FOSTER HOMES/TREATMENT FOSTER HOMES
CIP 1A/B, BIW and CLTS (Developmental Disabilities)

SPC 203

DEFINITION

A Children's Foster Home is a family oriented residence operated by a person licensed under §48.62, of the Wisconsin Statutes, and HFS 56 of the Administrative Code as a Foster Home, or residences operated by a provider licensed under HFS 38 of the Administrative Code as a Treatment Foster Home. Children's Foster Homes and Treatment Foster Homes provide care and maintenance for no more than four foster children, with exceptions for more children if all the foster children are siblings. Services provided by these homes are for children who need support in one or more aspects of their lives including health care; personal care; supervision; behavior and social supports, daily living skills training, and transportation.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. Excludes the cost of room and board provided by the Foster Home provider. Other disability or foster care-related funding sources generally cover these costs. Room and board costs are generally reimbursed by sources used to finance basic foster care.

2. Excludes the cost of basic support and supervision provided to children by foster care providers in these settings. These services are minimal and routine for children of the age of the child being served. Compensation for these services are not covered by the Medicaid Waivers and are generally covered by other funding sources associated with Foster Home.

3. Includes supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs or physical or personal care needs.

   Examples to illustrate the range and scope of children's exceptional emotional or behavioral care needs include severe hyperactivity to the point of destructiveness or sleeplessness; chronic withdrawal, depression or anxiety; self-injurious behavior, aggressive or violent behavior; history of running away for long periods of time; severe conduct or attachment disorders resulting in a significant level of acting out behavior; psychotic or delusional symptoms; eating disorders; repeated and uncontrollable social behavior resulting in property offenses, assualt, arson, or sexual perpetrator behaviors such that comprehensive and intensive supervision and intervention are required throughout the day. Examples to illustrate the range and scope of children's exceptional physical or personal care needs include: uncontrolled seizures; orthotic devices or appliances for drainage, a colostomy, or other similar device; requires direct assistance with personal cares, exhibits eating or feeding problems including tube or gavage feedings, requires specialized skin and positioning care to

treat or prevent serious skin conditions such as pressure sores, requires follow-through on a therapy plan in excess of 2 hours per day, requires persistent monitoring of complex medical needs, or is non-ambulatory.

4. For children with physical or personal care needs, the types of activities that may be applied include direct personal care provision beyond those age activities expected for a child, skilled tasks such as tube or gavage feedings, catherterization, close supervision and monitoring of a child with complex medical needs, follow through on specific therapeutic interventions, and frequent positioning or specialized skin care. For children with emotional or behavioral care needs, the types of activities or interventions that may be applied include follow through on a comprehensive behavioral intervention plan, structuring the child's environment to provide a significant level of predictability, organization and routine to minimize disruptive behaviors or address complex emotional needs, structuring the child's environment to prevent aggression, elopement or other disruptive or violent behaviors.

5. Foster Home providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the foster care providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care. .

6. The support and supervision costs of serving the children with disabilities served may be established at a higher rate if the provider must serve fewer children because of the extra or exceptional care and supervision needs of the children placed in the home described in 3 above. To illustrate this, if a provider could otherwise serve four children and therefore be compensated at a higher amount, the amount they receive for the care they provide to the child with a disability may be adjusted to compensate for this difference.

7. Transportation services may be included under this service or separately billed under the service Specialized Transportation so long as there is no duplicate billing for any unit of service.

8. Excludes environmental modifications to the home, adaptive equipment or communication aids under this service. Any needed environmental modification, adaptive equipment or communication aid may be covered by the Waiver but must be claimed under the services "Home Modifications," "Communication Aids or "Adaptive Equipment" respectively.

9. If Personal Care covered by the Medicaid State Plan is used by children served in the home, these services may not duplicate for services provided by the foster care providers.

10. Joint approval from DCFS and BDDS is required for the use of shift staff in a Treatment Foster Home prior to the placement of any Waiver participant in the home.

11. All persons providing services and supports to any Waiver participant shall be subject to a criminal and caregiver background check before they begin providing services. Both types of background checks must be repeated every fours years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

12. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter 9.

STANDARDS

Foster homes must be licensed under HFS 56 FAMILY FOSTER CARE FOR CHILDREN or HFS 38 for Treatment Foster Homes.

DOCUMENTATION

1. All providers of foster care must have evidence of valid licensure.

2. The county agency must document that no Waiver funds are being used to reimburse room and board costs.

3. There must be documentation of current criminal and caregiver background checks in the provider or licensing file.

4. There must be documentation that the services provided by the foster home sponsor do not duplicate personal care services if personal care services are also provided.

5. There must be documentation of the specific exceptional needs of the child and the individual psychiatric/behavioral care plan or individual medical care plan that the foster care provider will implement.

6. There must be documentation of the specific training the foster parent received related to the child’s needs and the psychiatric/behavioral treatment plan or individual medical care plan.

CHILDREN'S FOSTER HOMES/TREATMENT FOSTER HOMES
CLTS MENTAL HEALTH WAIVER

SPC 203

DEFINITION

A Children's Foster Home is a family oriented residence operated by a person licensed under §48.62, of the Wisconsin Statutes, and HFS 56 of the Administrative Code as a Foster Home, or residences operated by a provider licensed under HFS 38 of the Administrative Code as a Treatment Foster Home. Children's Foster Homes and Treatment Foster Homes provide care and maintenance for no more than four foster children, with exceptions for more children if all the foster children are siblings. Services provided by these homes are for children who need support in one or more aspects of their lives including health care; personal care; supervision; behavior and social supports, daily living skills training, and transportation.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. Excludes the cost of room and board provided by the Foster Care provider. Other disability or foster care-related funding sources generally cover these costs. Room and board costs are generally reimbursed by sources used to finance basic foster care.

2. Excludes the cost of basic support and supervision provided to children by foster care providers in these settings. These services are minimal and routine for children of the age of the child being served. Compensation for these services are not covered by the Medicaid Waivers and are generally covered by other funding sources associated with Foster Care.

3. Includes supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs. Examples to illustrate the range and scope of children's exceptional care needs include severe hyperactivity to the point of destructiveness or sleeplessness; chronic withdrawal, depression or anxiety; self-injurious behavior, aggressive or violent behavior; history of running away for long periods of time; severe conduct or attachment disorders resulting in a significant level of acting out behavior; psychotic or delusional symptoms; eating disorders; repeated and uncontrollable social behavior resulting in property offenses, assault, arson, or sexual perpetrator behaviors such that comprehensive and intensive supervision and intervention are required throughout the day.

4. Foster Care providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure their health, safety and welfare. These unique needs are generally related to

emotional and behavioral needs. The foster care providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.

5. For children with emotional or behavioral care needs, the types of activities or interventions that may be applied include follow through on a comprehensive behavioral intervention plan, structuring the child's environment to provide a significant level of predictability, organization and routine to minimize disruptive behaviors or address complex emotional needs, structuring the child's environment to prevent aggression, elopement or other disruptive or violent behaviors.

6. The support and supervision costs of serving the children with disabilities served may be established at a higher rate if the provider must serve fewer children because of the extra or exceptional care and supervision needs of the children placed in the home described in 3 above. To illustrate this, if a provider could otherwise serve four children and therefore be compensated at a higher amount, the amount they receive for the care they provide to the child with a disability may be adjusted to compensate for this difference.

7. Transportation services may be included under this service or separately billed under the service Specialized Transportation so long as there is no duplicate billing for any unit of service.

8. Excludes environmental modifications to the home, adaptive equipment or communication aids under this service. Any needed environmental modification, adaptive equipment or communication aid may be covered by the Waiver but must be claimed under the services "Home Modifications," "Communication Aids or "Adaptive Equipment" respectively.

9. If Personal Care covered by the Medicaid State Plan is used by children served in the home, these services may not duplicate for services provided by the foster care providers.

10. Joint approval from DCFS and BDDS is required for the use of shift staff in a Treatment Foster Home prior to the placement of any Waiver participant in the home.

11. All persons providing services and supports to any Waiver participant shall be subject to a criminal and caregiver background check before they begin providing services. Both types of background checks must be repeated every fours years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. General provider screening requirements for Medicaid Waivers apply to this service.

12. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter 9.

STANDARDS

Foster homes must be licensed under HFS 56 FAMILY FOSTER CARE FOR CHILDREN or HFS 38 for Treatment Foster Homes.

DOCUMENTATION

1. All providers of foster care must have evidence of valid licensure.

2. The county agency must document that no Waiver funds are being used to reimburse room and board costs.

3. There must be documentation of current criminal and caregiver background checks in the provider or licensing file.

4. There must be documentation that the services provided by the foster home sponsor do not duplicate personal care services if personal care services are also provided.

5. There must be documentation of the specific exceptional needs of the child and the individual psychiatric/behavioral care plan that the foster care provider will implement.

6. There must be documentation of the specific training the foster parent received related to the child's needs and the psychiatric/behavioral treatment plan.

CHILDREN'S FOSTER HOMES/TREATMENT FOSTER HOMES
CLTS PHYSICAL DISABILITY WAIVER

SPC 203

DEFINITION

A Children's Foster Home is a family oriented residence operated by a person licensed under §48.62, of the Wisconsin Statutes, and HFS 56 of the Administrative Code as a Foster Home, or residences operated by a provider licensed under HFS 38 of the Administrative Code as a Treatment Foster Home. Children's Foster Homes and Treatment Foster Homes provide care and maintenance for no more than four foster children, with exceptions for more children if all the foster children are siblings. Services provided by these homes are for children who need support in one or more aspects of their lives including health care; personal care; supervision; behavior and social supports, daily living skills training, and transportation.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. Excludes the cost of room and board provided by the Foster Care provider. Other disability or foster care-related funding sources generally cover these costs. Room and board costs are generally reimbursed by sources used to finance basic foster care.

2. Excludes the cost of basic support and supervision provided to children by foster care providers in these settings. These services are minimal and routine for children of the age of the child being served. Compensation for these services are not covered by the Medicaid Waivers and are generally covered by other funding sources associated with Foster Care.

3. Includes supplementary intensive supports and supervision services to address exceptional physical or personal care needs. Examples to illustrate the range and scope of children's exceptional care needs include: uncontrolled seizures; orthotic devices or appliances for drainage, a colostomy, or other similar device; requires direct assistance with personal cares, exhibits eating or feeding problems including tube or gavage feedings, requires specialized skin and positioning care to treat or prevent serious skin conditions such as pressure sores, requires follow-through on a therapy plan in excess of two hours per day, requires persistent monitoring of complex medical needs, or is non-ambulatory.

4. The types of activities that may be applied include direct personal care provision beyond those age activities expected for a child, skilled tasks such as tube or gavage feedings, catherterization, close supervision and monitoring of a child with complex medical needs, follow through on specific therapeutic interventions, and frequent positioning or specialized skin care.

5. Foster Care providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure their health, safety and welfare. These unique needs are generally related to physical, medical and personal care. The provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.

6. The support and supervision costs of serving the children with disabilities served may be established at a higher rate if the provider must serve fewer children because of the extra or exceptional care and supervision needs of the children placed in the home described in 3 above. To illustrate this, if a provider could otherwise serve four children and therefore be compensated at a higher amount, the amount they receive for the care they provide to the child with a disability may be adjusted to compensate for this difference.

7. Transportation services may be included under this service or separately billed under the service Specialized Transportation so long as there is no duplicate billing for any unit of service.

8. Excludes environmental modifications to the home, adaptive equipment or communication aids under this service. Any needed environmental modification, adaptive equipment or communication aid may be covered by the Waiver but must be claimed under the services "Home Modifications," "Communication Aids or "Adaptive Equipment" respectively.

9. If Personal Care covered by the Medicaid State Plan is used by children served in the home, these services may not duplicate for services provided by the foster care providers.

10. Joint approval from DCFS and BDDS is required for the use of shift staff in a Treatment Foster Home prior to the placement of any Waiver participant in the home.

11. All persons providing services and supports to any Waiver participant shall be subject to a criminal and caregiver background check before they begin providing services. Both types of background checks must be repeated every fours years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. General provider screening requirements for Medicaid Waivers apply to this service.

12. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter 9.

STANDARDS

Foster homes must be licensed under HFS 56 FAMILY FOSTER CARE FOR CHILDREN or HFS 38 for Treatment Foster Homes.

DOCUMENTATION

1. All providers of foster care must have evidence of valid licensure.

2. The county agency must document that no Waiver funds are being used to reimburse room and board costs.

3. There must be documentation of current criminal and caregiver background checks in the provider or licensing file.

4. There must be documentation that the services provided by the foster home sponsor do not duplicate personal care services if personal care services are also provided.

5. There must be documentation of the specific exceptional needs of the child and the individual medical care plan that the foster care provider will implement.

6. There must be documentation of the specific training the foster parent received related to the child's needs and the treatment plan.

COMMUNICATION AIDS

SPC 112.47

DEFINITION

Communication Aids are devices or services necessary to assist persons with hearing, speech or vision impairments to effectively communicate with, family, friends, the general public and service providers. Communication Aids covered by this service include any device that assists the Waiver participant to achieve the objective of this service. The kind of device envisioned is illustrated by the devices listed below. Devices not on this list may also be covered. This is intended to permit efficient and effective responses to new technologies. This list is not intended to be all-inclusive. The cost of installation, repair, maintenance and support of any covered communication aid are also covered by this service. Communication aids can include:

1. Assistive listening devices
2. Telecommunication equipment
3. Low vision magnification devices
4. Braille writing equipment
5. Augmentative communications devices
6. Visual fire alarm systems
7. Direct selection communicators
8. Alphanumeric, scanning or encoding communicators
9. Speech amplifiers
10. Interpreter services
11. Cell phones
12. Computers

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Only Communication Aids that cannot be obtained under Wisconsin's approved Medicaid State Plan will be paid for by Waiver funds.

2. Prior approval assuring the need for Communication Aids costing in excess of $1000 must be obtained from a licensed Speech Therapist or Speech Pathologist, Occupational Therapist, Physical Therapist, Rehabilitation Organization or Independent Living Center.

3. Waiver participants may receive only one computer as an approved communication aid or as a covered item under a different service. This does not include replacements.

STANDARDS

1. All Communication Aids must meet Underwriter's Laboratory or Federal Communications Commission standards when applicable.

2. Communication Aids should be obtained from authorized dealers of the specific product where applicable.

3. For interpreter services, a qualified interpreter is a person who is certified by the National Registry for Interpreters for the Deaf (RID) or who has successfully participated in the DHFS, State Bureau for the Deaf and Hard of Hearing "Wisconsin Interpreting and Transliterating Assessment (WITA)."

DOCUMENTATION

1. For Communication Aids costing in excess of $1000, the county must obtain documentation of prior approval by a Speech Therapist or Speech Pathologist, Occupational Therapist, Physical Therapist, Rehabilitation Organization or Independent Living Center assuring the need for the Communication Aid.

2. There should be documentation in the participant file or a provider file that providers of interpreter services meet the required standards. The county agency may include verification of provider qualifications in the contract or provider agreement with the agency or individual providing interpreter services.

3. When the communication aid includes a computer, the ISP shall state that the computer purchased shall be used for any other covered service that includes the use of a computer.

COMMUNITY BASED RESIDENTIAL FACILITY

SPC 506.61 CBRF 5-8 Beds

DEFINITION

The provision of services in and by staff of a Community Based Residential Facility (CBRF). CBRFs are defined in Section 50.01 (1g) Wi Stats. and Chapter HFS 83.03 of the Wisconsin Administrative Code. Providers shall conform to the statutory definition of such facilities.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. CBRFs must be licensed under the provisions of HFS 83. All definitions, requirements and provisions of that licensing rule apply to this service.

2. A variance must be granted to allow a county to receive funding for this service under the CIP 1A, CIP 1B and BIW Medicaid Waiver Programs. See Chapter 5 of the Medicaid Waivers Manual for variance procedures and approval criteria.

3. Pursuant to the requirements in HFS 83, the CBRF operator and all persons providing services and supports shall be subject to criminal and caregiver background check before they begin employment. Both of these background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. Persons providing services in and for a CBRF shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual or equivalent standards.

4. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9.

STANDARDS

HFS 83 Community Based Residential Facilities are the standards governing this service.

DOCUMENTATION

1. The provider must have a current CBRF license.

2. Variances to permit the funding of this service shall be kept in the participant's record.

CONSUMER-DIRECTED SUPPORTS

SPC 609.10

DEFINITION

The provision of a flexible array of services provided to participants that include a specified portion of the services covered by the Waiver. Services are planned and implemented through processes characterized by:

1. Support for the consumer and those close to the consumer to assist in identifying the consumer's goals and means of reaching those goals, in a manner that reflects consumer preferences as closely as possible;

2. Planning that occurs within the limits of an individualized budget that is based on typical service costs for Waiver participants with similar needs in similar situations; and

3. An emphasis on identifying and strengthening networks of informal supports and on making use of generic community resources to the maximum extent possible.

4. Processes and supports for person-centered service planning and implementation that are established through a locally developed county Consumer-directed Services (CDS) implementation plan and memorandum of understanding (MOU) with the department.

   Processes and supports for service planning, implementation, operation and monitoring are established through a locally developed county implementation plan that is subject to approval by the department. Based on this plan, a Memorandum of Understanding (MOU) is executed between the county and department. This MOU governs the operation of this service for the county.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. This service is only available if the county has a Memorandum of Understanding with the Department. Department agreement with the MOU constitutes approval to provide this service.

2. The MOU shall describe the county's plan for how they intend to address the following program elements with an emphasis on how they differ from Waiver service provision done outside the context of this service:
   a. Outreach and Public education;
   b. A description of all of the methods to be used in soliciting public, consumer and guardian comment on the method used in individual budgeting. Said method must be continuously available for public review and must be periodically reevaluated.
   c. Participant education on all aspects of the CDS program;
   d. Support and service coordination including any use of service brokers describing the role of both of these types of providers;

e. The content of assessments and person-centered, individualized service plans;
f. The methods to be used in setting individual budgets must be described;
g. Methods to be used in budget problem solving must be specified;
h. The nature and scope of financial assistance provided to CDS participants;
i. The strategy and policies associated with the use of informal supports;
j. The scope of services that will be available under this service as provided by the county; and
k. The methods, if different, that will be used to assure health and safety and access to assistance in asserting rights under law and rule.

3. The array of Waiver-covered services included in Consumer-directed Services includes all services covered by this Waiver except CBRF services, Adult Family Home services in 1-2 bed and 3-4 bed homes, Children's Foster Home/Treatment Foster Home Services and Support and Service Coordination.

4. Includes additional support and service coordination and arrangement if provided by support brokers or someone described in the approved MOU. This person may be someone other than and in addition to the regular Support and Service Coordinator.

5. Provider Screening Requirements: All persons providing any Waiver-covered service under this service category shall be subject to criminal and caregiver background checks before they begin employment. This includes all informal supports and natural caregivers if they are paid to provide the service. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

6. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9.

STANDARDS

1. Providers under Consumer-Directed Supports (CDS) must have skills and knowledge needed to carry out responsibilities assigned to them in a manner that meets the individual needs and preferences of the participant as specified in the individual service plan and in a manner that ensures protection of participant health and safety and observance of participant rights.

2. The County and Consumer-Directed Services provider shall comply with all provisions of the approved MOU. Department approval of the MOU constitutes qualification of the county as a provider of CDS.

3. Counties shall have a method to share the method used in individual budgeting that is subject to continuous public review and not less than annual reevaluation.

4. Other services provided to participants of Consumer-Directed Services must meet the standards for those services.

5. Consumer-Directed Service providers shall meet the standards for the Waiver-covered service they provide or meet provider qualifications that are based on the needs and characteristics of the specific individual or individuals served.

6. Each individual must have an annual budget document that lists total expenditures for each participant by type of expense.

DOCUMENTATION

1. There must be an annual budget document in each participant's file. The basis for calculation of the individual's budget should also be in the participant's file.

2. Evidence of qualifications of all Waiver providers that provide covered Waiver service under CDS must be in the participant's file.

3. There must be documentation that the person's individualized plan reflects Waiver participant's views and preferences and that the goals and outcomes sought are those of the Waiver participant. This description shall include the basis for this conclusion.

4. The individualized plan must document the purpose of all expenditures made for each individual under this service.

5. Evidence that the services billed were actually delivered must be in the county file.

6. Evidence that the background checks that comply with the requirements for this service on care or service providers have been completed must be in the participant file.

CONSUMER AND FAMILY DIRECTED-SUPPORTS

SPC 609.20

DEFINITION

Consumer and Family-Directed Supports are designed to assist children and their families to build, strengthen, or maintain informal networks of community supports. Consumer and Family-Directed Supports include the following specific activities at the request and direction of the child or his/her family. The types of services and supports provided through Consumer and Family-directed supports are the same as other Waiver allowable services and include: adaptive aides, communication aides, consumer education and training, counseling and therapeutic resources, daily living skills training, day services, foster care, home modifications, personal emergency response, respite care, specialized medical and therapeutic supplies, specialized transportation, supported employment, and supportive home care. The provider for each service and support must meet the provider qualifications for the individual service as noted under this Waiver. The method of arranging for the provision of services and the supervision of these services will occur as described below. These activities include provision of support, care and assistance to the child and family, to prevent out-of-home placement of the child, and to support the child's inclusion in the community. Representative examples include:

a. Provision of services and supports, which assist the child, family, or friends to:

- Identify and access formal and informal support systems;
- Develop a meaningful child and family support plan; or
- Increase and/or maintain the capacity to direct formal and informal resources.

b. Completion of activities which assist the child, family, and friends to determine future plans.

c. Development and implementation of family-centered support plan, which provides the direction, assistance and support to allow the person with a disability to live in the community, establish meaningful community associations, and make valued contributions to the community.

d. Ongoing consultation, community support, training, problem-solving, and technical assistance to assure successful implementation of a family-centered plan.

e. Development and implementation of community support strategies, which aid and strengthen the involvement of community members who assist the child to live in the community.

Services provided under a plan for Consumer and Family-Directed Supports may not duplicate any other services provided to the person. Components of Consumer and Family-Directed Supports will be documented in the child and family support plan to prevent out-of-home placement of the child. The local agency shall document how the community support services

enable the person to lead an inclusive community life, build a viable network of support, and result in outcomes specified by the child and family. The local agency shall also document that the supports and service assure the child's health and safety needs, including the use of providers who meet appropriate qualification and skills for the particular service provided, as well as assurance of Freedom of Choice for all services and supports.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

Wisconsin will cover Consumer and Family-Directed Supports in areas of the state in which local agencies have memorandums of understanding with the state agency to demonstrate the feasibility and effectiveness of Consumer and Family-Directed Supports. Each local agency offering family-directed support services will develop a written plan to implement Consumer and Family-Directed Supports, which will:

- Specify how children, families and other natural supports were involved in developing the plan and will be involved in ongoing oversight of the plan.

- Specify how the local agency will provide information about Consumer and Family-Directed Supports to consumers, families and other natural supports and providers.

- Specify how participating children and their families, guardians and other natural supports will be supported to: know their rights as citizens and consumers; learn about the methods provided by the Consumer and Family-Directed Supports plan to take greater control of decision-making; and develop skills to be more effective in identifying and implementing personal goals.

- Establish support for development of family-centered support plans which are based on individual goals and preferences and which allow the person with a disability to live in the community, establish meaningful community associations, and make valued contributions to the community.

- Provide for mechanisms for consultation, problem-solving, and technical assistance to assist consumers in accessing and developing the desired support(s), and to assist in securing administrative and financial management assistance to implement the supports(s).

- Establish a mechanism for allocating resources to individuals for the purpose of purchasing family-directed community support services based upon identified factors. These factors may include the person's skills, his/her environment, the supports available to the person, and the specialized support needs of the person.

- Describe how the local agency will promote use of informal and generic sources of support.

- Describe how the county will promote availability of a flexible array of services that is able to provide supports to meet identified needs and that is able to provide consumer

choice as to nature, level and location of services.

- Describe how the local agency will assure that Consumer and Family-Directed Supports meet the child's health and safety needs.

- Provide for outcome-based quality assurance methods.

Consumer and Family-Directed Supports are services, which provide support, care and assistance to an individual with a disability, prevent out-of-home placement of the child, and allow the child to live an inclusive life. Consumer and Family-Directed Supports are designed to build, strengthen or maintain informal networks of community support for the person.

CONSUMER EDUCATION AND TRAINING

SPC 113

DEFINITION

The provision of services to help a person with a disability develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. Education may also include individualized tutoring, individual instruction, and educational related services to the extent which they are not permitted under a program funded by the Individuals with Disabilities Education Act (IDEA). Expenses for this service may include enrollment fees, materials, transportation, related to participation in courses, conferences and other similar events that address the objective of Consumer Education and Training. Payments may be directed to the consumer by the local agency to allow the consumer to receive the needed training or education.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Education and training for parents or guardians must be specific and related to developing the skills needed to meet the Waiver participant's unique support needs.

2. Local agencies will assure that the consumer and legal guardian receive necessary information on training and educational opportunities related to identified goals.

3. For Children, educationally related services cannot be provided unless there is a compelling and accepted reason and sufficient documentation that the service is not available under IDEA, the Rehabilitation Act of 1973 or other relevant funding sources.

4. Payment will not exceed $2500 per recipient annually.

5. Excludes reimbursement for hotel and meal expenses for Waiver participants, their family members and their guardians while attending courses or conferences.

STANDARDS

Consumer Education and Training will be provided by individuals, agencies or educational facilities which have expertise in such areas as consumer empowerment, consumer-directed supports, self-advocacy, community inclusion, relationship building, problem solving, financial management and decision-making.

DOCUMENTATION

1. Training and education goals related to these outcomes will be documented in the individual service plan.

2. Documentation of how specific training relates to identified goals will be included in the individual service plan.

3. Receipts for allowable fees and expenses must be submitted to the local agency to verify accurate payment.

COUNSELING AND THERAPEUTIC SERVICES

SPC 507.03

DEFINITION

The provision of services to participants with personal, social, behavioral, mental, cognitive, substance abuse, developmental or medical needs to maintain or improve participant health, welfare or functioning in the community. May include services that address any of these objectives. The following list illustrates the kinds of services that may be included under this service. This list is not all-inclusive but is intended to illustrate the services that may be purchased under this service category. May include counseling, psychotherapy, recreational therapies, music therapy and nutritional counseling.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Only those services not reimbursable under Wisconsin's State Medicaid Plan may be reimbursed with Waiver funds.

2. The cost of transportation may either be included in the rate paid to the provider of this service or may be covered and reimbursed under Specialized Transportation but not both.

3. Any counseling or therapeutic service funded by the Waiver program must be directly related to a therapeutic goal.

4. Provider Screening Requirements: All persons who provide this service shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of these services such as misappropriation of participant funds shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

5. All providers that have direct contact with the Waiver participant must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9

STANDARDS

1. The individual providing counseling services, except for medical counseling, shall have the skills and knowledge that would be typically acquired through a course of study leading to a master's degree in one of the behavioral sciences and one year of training or experience in the specific area in which counseling is being offered. Medical counseling shall be provided by

a licensed physician or a registered professional nurse in accord with the Professional Practice Act.

2. Other counselors or therapists shall be professionally licensed and certified in the appropriate field.

DOCUMENTATION

1. All providers of this service shall send a written progress report to the Support and Service Coordinator at least every six months.

2. For billing purposes, provider records must document the provision of services. This can be done in case notes, time logs or some other format. Documentation must also include evidence that the units of service billed were actually provided.

3. If the service is covered by the Wisconsin Medicaid State Plan, evidence of a denial must be present in the file.

4. The therapeutic purpose of the service and its relationship to the needs of the participant shall be documented in the participant's record.

DAILY LIVING SKILLS TRAINING

SPC 110

DEFINITION

The provision of services to participants who need instruction and guidance to successfully complete routine daily living tasks. Services are intended to improve the participant's ability to perform routine daily living tasks and utilize community resources more independently. Services are focussed on skill development and are not designed to provide substitute task performance. Daily Living Skills Training includes skill development in the following areas:

1. Parenting
2. Money management,
3. Home upkeep and maintenance
4. Food preparation
5. Accessing and using community resources
6. Community mobility training
7. Personal hygiene

The major distinction between Daily Living Skills Training and Supportive Home Care services is Daily Living Skills Training is intended to teach participants to perform activities with greater independence while supportive home care involves doing tasks the person is not able to do themselves.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes performance of tasks for the person unless these are done to train the person on how to do these himself or herself. Performing the task for the person is Supportive Home Care.

2. Provider Screening Requirements: All persons providing this service shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

3. All providers must communicate with designated county staff and other providers within the limits of confidentiality laws and rules about critical incidents as defined in the Medicaid Waivers Manual, Chapter 9 and memo DSL 03-02.

STANDARDS

1. The providers of Daily Living Skills Training are required to have a minimum of two years experience working with persons with a disability. In lieu of experience, the county is required to ensure that the provider is given participant specific training to work towards the objectives outlined in the service plan.

2. The ratio and qualifications of personnel shall be adequate to meet the specific needs of the participant(s) receiving services.

3. Providers of Daily Living Skills Training or their supervisors shall prepare and send a written report to the county Waiver agency at least every six months. The report shall contain a statement on progress the participant is making toward achieving the objectives of the service plan. The report may also include recommendations for changes in this service.

DOCUMENTATION

1. The county must be able to provide documentation of qualifications of personnel providing Daily Living Skills Training

2. The required six month progress report must be filed in the participant record. This report may be completed in conjunction with other reviews such as the six-month and annual review of the participant's Individual Service Plan.

3. Documentation of current caregiver and criminal background checks of all day care staff must be available and easily accessed upon request. This documentation may be in either each participant's county file or the county's provider files.

4. The county or contract agency must be able to produce documentation attesting to the qualifications of personnel providing Daily Living Skills Training. For contracted services, the county may include a statement in the agency contract or provider agreement verifying that the provider meets all required qualifications.

5. The required written reports may be included as a part of other reviews such as the six-month and annual review of the Waiver participant's Individual Service Plan.

DAY SERVICES-ADULTS

SPC 706.10

DEFINITION

Day Services is the provision of regularly scheduled, recurring, activities for a defined period occurring for a number of days during a typical week to develop a participant's social skills and to promote community integration. Services are typically provided four or more hours per day, up to five days per week outside of the person's home. Services may occur in a single physical environment or in multiple environments, including the community.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes day services aimed primarily to elderly adults including elderly adults with a developmental disability or traumatic brain injury intended to provide socially stimulating activities and peer contacts during part of the day. This type of service is Adult Day Care.

2. Day services must include some type of skill training and involve services above the level of supervision. Supervision only in a congregate day setting must be classified as Adult Day Care, Supportive Home Care, Personal Care or Respite Care-Other and must meet the requirements of one of those services.

3. Provider Screening Requirements: All persons providing this service shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

4. Providers must communicate with county staff and other providers within confidentiality laws any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9.

STANDARDS

1. A day program must have a director who has the skills and knowledge typically acquired through a course of study leading to a bachelor's degree in a human services field and have a minimum of two years' experience working with the target groups covered by this service.

2. All Day Services staff must meet the standards for Supportive Home Care personnel listed in the standards section of that service.

3. There shall be a minimum of one direct service staff for every 15 people receiving day services. This ratio of staff to program participant may need to be lower if the specific needs of the actual individuals being served by the provider require additional hands on support and supervision of Waiver participants.

4. Day Services for adults shall include at least one of the following programs:
   a. Independent and daily living skills
   b. Mobility skills
   c. Social, emotional, and personal development
   d. Communication skills
   e. Community integration

5. A progress report containing a statement on progress toward objectives of the individual service plan and recommendations for change must be done not less than every six months or more frequently if warranted.

6. Day Service settings for adults that have valid certification from the Rehabilitation Accreditation Commission for Activity Services are deemed qualified providers for the purposes of Medicaid Waivers. RAC accreditation is accepted in lieu of county verification of provider qualifications.

DOCUMENTATION

1. The county agency must maintain documentation that the provider meets the standards for Day Services programs.

2. The required progress report and all such reports for the prior two years must be available in the participant's provider file and submitted and filed with the county service coordinator in county files.

3. The ratio of direct service staff needed to the assessed needs of the specific participants served at any time must be documented. Participant records held by the provider must identify any person or person's with additional, more intensive needs for support and supervision and document that this support and supervision is being provided.

4. Documentation of current caregiver and criminal background checks of all day care staff must be available and easily accessed upon request. This documentation may be in either each participant's county file or the county's provider files.

DAY SERVICES-CHILDREN
DEVELOPMENTAL DISABILITIES WAIVER

SPC 706.20

DEFINITION

The provision of services that provide children with regularly scheduled activities for part of the day. Services include training, coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration and domestic and economic management. This includes services not otherwise available through public education programs that provide after school supervision, daytime services when school is not in session, and services to pre-school age children. Services are typically provided up to five days per week in a non-residential setting and may occur in a single physical environment or in multiple environments, including natural settings in the community. Training activities may involve children and their families. Coordination activities may involve the implementation of components of the child's the family-centered and individualized service plans and may involve family, professionals, and others involved with the child as directed by the child's plan. Day Services for children also include the provision of supplementary staffing necessary to meet the child's exceptional care needs. Day Services for children also include the provision of supplementary staffing necessary to meet the child's exceptional care needs.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes any services available through public education programs funded under the Individuals with Disabilities Education Act.

2. Excludes the basic cost of day care unrelated to a child's disability needed by parents or regular caregivers to allow them to work or participate in educational or vocational training programs. The "basic cost of day care" here means the rate charged by and paid to a child care center for children who do not have special needs. Basic cost of child care does not include the provision of supplementary staffing and environmental modifications necessary to provide accessibility at regular child care settings; these costs can be covered by this service.

3. Excludes any service that falls under the definition of daily living skills training, prevocational services, or respite care.

4. Includes supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs; or physical or personal care needs.

   Examples to illustrate the range and scope of children's exceptional emotional or behavioral care needs include severe hyperactivity to the point of destructiveness or sleeplessness; chronic withdrawal, depression or anxiety; self-injurious behavior, aggressive or violent

behavior; history of running away for long periods of time; severe conduct or attachment disorders resulting in a significant level of acting out behavior; psychotic or delusional symptoms; eating disorders; repeated and uncontrollable social behavior resulting in property offenses, assault, arson, or sexual perpetrator behaviors such that comprehensive and intensive supervision and intervention are required throughout the day. Examples to illustrate the range and scope of children's exceptional physical or personal care needs include: uncontrolled seizures; orthotic devices or appliances for drainage, a colostomy, or other similar device; requires direct assistance with personal cares, exhibits eating or feeding problems including tube or gavage feedings, requires specialized skin and positioning care to treat or prevent serious skin conditions such as pressure sores, requires follow-through on a therapy plan in excess of 2 hours per day, requires persistent monitoring of complex medical needs, or is non-ambulatory.

5. For children with physical or personal care needs, the types of activities that may be applied include direct personal care provision beyond those age activities expected for a child, skilled tasks such as tube or gavage feedings, catherterization, close supervision and monitoring of a child with complex medical needs, follow through on specific therapeutic interventions, and frequent positioning or specialized skin care. For children with emotional or behavioral care needs, the types of activities or interventions that may be applied include follow through on a comprehensive behavioral intervention plan, structuring the child's environment to provide a significant level of predictability, organization and routine to minimize disruptive behaviors or address complex emotional needs, structuring the child's environment to prevent aggression, elopement or other disruptive or violent behaviors.

6. Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure their health, safety and welfare. . If these unique needs are generally related to emotional and behavioral needs the foster care providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.

7. All children's day services program must be licensed under applicable requirements of HFS 55.

8. A criminal and caregiver background check for all persons providing direct care to any child must be conducted. Both of these background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of this service shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

9. Providers must communicate with county staff and other providers within confidentiality laws, any incidents or situations regarded as Critical Incidents as defined in the Medicaid Home and Community-Based Services Waivers Manual, Chapter 9.

STANDARDS

1. Staff in Child Care setting for Children who work directly with children must have a combination of one year of training in child development or in program-serving children.

2. Family Child Care Centers must be licensed under HFS 55, Licensing Rules for Family Child Care Centers.

3. Group Child Care Center means a center that provides care and supervision for nine or more children. Group Child Care Centers must be licensed under HFS 55, Licensing Rules for Group Child Care Centers.

4. There must be documentation of the specific exceptional needs of the child and the individual psychiatric/behavioral care plan or individual medical care plan that the foster care provider will implement.

5. There must be documentation of the specific training the foster parent received related to the child's needs and the psychiatric/behavioral treatment plan or individual medical care plan.

DOCUMENTATION

1. The county agency must maintain documentation that the provider has the qualifications contained in this section and meets the applicable standards for providers of the type of Day Services program offered.

2. A progress report containing a statement on progress toward objectives of the individual service plan and recommendations for change must be filed in the county copy of the participant record not less than once every six months.

3. The provider must have evidence of current licensure or certification under the applicable provision of HFS 55 Licensing Rules for Family Child Care Centers or Licensing Rules for Group Child Care Centers.

4. When the day service program involves work, school or training related child day care, there should be documentation about specific costs of the supplementary staff or environmental modifications funded under this service.

5. Documentation of current caregiver and criminal background checks of all day care staff must be available and easily accessed upon request. This documentation may be in either each participant's county file or the county's provider files.

6. There must be documentation of the specific exceptional needs of the child and the individual psychiatric/behavioral care plan or individual medical care plan that the foster care provider will implement.

7. There must be documentation of the specific training the foster parent received related to the child's needs and the psychiatric/behavioral treatment plan or individual medical care plan.

DAY SERVICES
MENTAL HEALTH WAIVER
SPC 706.20 CHILDREN

DEFINITION

The provision of services that provide children with regularly scheduled activities for part of the day. Services include training, coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration and domestic and economic management. This includes services not otherwise available through public education programs that provide after school supervision, daytime services when school is not in session, and services to pre-school age children. Services are typically provided up to five days per week in a non-residential setting and may occur in a single physical environment or in multiple environments, including natural settings in the community. Training activities may involve children and their families. Coordination activities may involve the implementation of components of the child's the family-centered and individualized service plans and may involve family, professionals, and others involved with the child as directed by the child's plan. Day Services for children also include the provision of supplementary staffing necessary to meet the child's exceptional care needs.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes any services available through public education programs funded under the Individuals with Disabilities Education Act.

2. Excludes the basic cost of day care unrelated to a child's disability needed by parents or regular caregivers to allow them to work or participate in educational or vocational training programs. The "basic cost of day care" here means the rate charged by and paid to a child care center for children who do not have special needs. Basic cost of child care does not include the provision of supplementary staffing and environmental modifications necessary to provide accessibility at regular child care settings; these costs can be covered by this service.

3. Excludes any service that falls under the definition of daily living skills training, prevocational services, or respite care.

4. Includes supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs. Examples to illustrate the range and scope of children's exceptional care needs include severe hyperactivity to the point of destructiveness or sleeplessness; chronic withdrawal, depression or anxiety; self-injurious behavior, aggressive or violent behavior; history of running away for long periods of time; severe conduct or attachment disorders resulting in a significant level of acting out behavior; psychotic or delusional symptoms; eating disorders; repeated and uncontrollable social

behavior resulting in property offenses, assault, arson, or sexual perpetrator behaviors such that comprehensive and intensive supervision and intervention are required throughout the day.

5. Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure their health, safety and welfare. These unique needs are generally related to emotional and behavioral needs. The child care providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.

6. For children with emotional or behavioral care needs, the types of activities or interventions that may be applied include follow through on a comprehensive behavioral intervention plan, structuring the child's environment to provide a significant level of predictability, organization and routine to minimize disruptive behaviors or address complex emotional needs, structuring the child's environment to prevent aggression, elopement or other disruptive or violent behaviors.

7. All children's day services program must be licensed under applicable requirements of HFS 55.

8. A criminal and caregiver background check for all persons providing direct care to any child must be conducted. Both of these background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of this service shall not be considered qualified for the provision of this service

9. Providers must communicate with county staff and other providers within confidentiality laws, any incidents or situations regarded as Critical Incidents as defined in the Medicaid Home and Community-Based Services Waivers Manual, Chapter 9.

STANDARDS

1. Staff in Child Care setting for Children who work directly with children must have a combination of one year of training in child development or in program-serving children.

2. Family Child Care Centers must be licensed under HFS 55, Licensing Rules for Family Child Care Centers.

3. Group Child Care Center means a center that provides care and supervision for nine or more children. Group Child Care Centers must be licensed under HFS 55, Licensing Rules for Group Child Care Centers.

DOCUMENTATION

1. The county agency must maintain documentation that the provider has the qualifications contained in this section and meets the applicable standards for providers of the type of Day Services program offered.

2. A progress report containing a statement on progress toward objectives of the individual service plan and recommendations for change must be filed in the county copy of the participant record not less than once every six months.

3. The provider must have evidence of current licensure or certification under the applicable provision of HFS 55 Licensing Rules for Family Child Care Centers or Licensing Rules for Group Child Care Centers.

4. When the day service program involves work, school or training related child day care, there should be documentation about specific costs of the supplementary staff or environmental modifications funded under this service.

5. Documentation of current caregiver and criminal background checks of all day care staff must be available and easily accessed upon request. This documentation may be in either each participant's county file or the county's provider files.

6. There must be documentation of the specific exceptional needs of the child and the individual psychiatric/behavioral care plan that the child care provider will implement.

7. There must be documentation of the specific training the child care provider received related to the child’s needs and the psychiatric/behavioral treatment plan.

DAY SERVICES
PHYSICAL DISABILTITES WAIVER
SPC 706.20 CHILDREN

DEFINITION

The provision of services that provide children with regularly scheduled activities for part of the day. Services include training, coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration and domestic and economic management. This includes services not otherwise available through public education programs that provide after school supervision, daytime services when school is not in session, and services to pre-school age children. Services are typically provided up to five days per week in a non-residential setting and may occur in a single physical environment or in multiple environments, including natural settings in the community. Training activities may involve children and their families. Coordination activities may involve the implementation of components of the child's the family-centered and individualized service plans and may involve family, professionals, and others involved with the child as directed by the child's plan. Day Services for children also include the provision of supplementary staffing necessary to meet the child's exceptional care needs.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes any services available through public education programs funded under the Individuals with Disabilities Education Act.

2. Excludes the basic cost of day care unrelated to a child's disability needed by parents or regular caregivers to allow them to work or participate in educational or vocational training programs. The "basic cost of day care" here means the rate charged by and paid to a child care center for children who do not have special needs. Basic cost of child care does not include the provision of supplementary staffing and environmental modifications necessary to provide accessibility at regular child care settings; these costs can be covered by this service.

3. Excludes any service that falls under the definition of daily living skills training, prevocational services, or respite care.

4. Includes supplementary intensive supports and supervision services to address exceptional physical or personal care needs. Examples to illustrate the range and scope of children's exceptional care needs include: uncontrolled seizures; orthotic devices or appliances for drainage, a colostomy, or other similar device; requires direct assistance with personal cares, exhibits eating or feeding problems including tube or gavage feedings, requires specialized skin and positioning care to treat or prevent serious skin conditions such as

pressure sores, requires follow-through on a therapy plan in excess of two hours per day, requires persistent monitoring of complex medical needs, or is non-ambulatory.

5. Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure their health, safety and welfare. These unique needs are generally related to physical, medical and personal care. The provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.

6. The types of activities that may be applied include direct personal care provision beyond those age activities expected for a child, skilled tasks such as tube or gavage feedings, catheterization, close supervision and monitoring of a child with complex medical needs, follow through on specific therapeutic interventions, and frequent positioning or specialized skin care.

7. All children's day services program must be licensed under applicable requirements of HFS 55.

8. A criminal and caregiver background check for all persons providing direct care to any child must be conducted. Both of these background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of this service shall not be considered qualified for the provision of this service

9. Providers must communicate with county staff and other providers within confidentiality laws, any incidents or situations regarded as Critical Incidents as defined in the Medicaid Home and Community-Based Services Waivers Manual, Chapter 9.

STANDARDS

1. Staff in Child Care setting for Children who work directly with children must have a combination of one year of training in child development or in program-serving children.

2. Family Child Care Centers must be licensed under HFS 55, Licensing Rules for Family Child Care Centers.

3. Group Child Care Center means a center that provides care and supervision for nine or more children. Group Child Care Centers must be licensed under HFS 55, Licensing Rules for Group Child Care Centers.

DOCUMENTATION

1. The county agency must maintain documentation that the provider has the qualifications contained in this section and meets the applicable standards for providers of the type of Day Services program offered.

2. A progress report containing a statement on progress toward objectives of the individual service plan and recommendations for change must be filed in the county copy of the participant record not less than once every six months.

3. The provider must have evidence of current licensure or certification under the applicable provision of HFS 55 Licensing Rules for Family Child Care Centers or Licensing Rules for Group Child Care Centers.

4. When the day service program involves work, school or training related child day care, there should be documentation about specific costs of the supplementary staff or environmental modifications funded under this service.

5. Documentation of current caregiver and criminal background checks of all day care staff must be available and easily accessed upon request. This documentation may be in either each participant's county file or the county's provider files.

6. There must be documentation of the specific exceptional needs of the child and the individual medical care plan that the child care provider will implement.

7. There must be documentation of the specific training the child care provider received related to the child’s needs and the treatment plan.

FINANCIAL MANAGEMENT SERVICES

SPC 619

DEFINITION

The provision of services to assist Waiver participants and their families manage service dollars. This service involves a person or agency paying service providers after the participant, guardian or family authorizes payment to be made for services included in the participant's approved individualized service plan. Financial Management Services providers, sometimes referred to as fiscal intermediaries, are organizations or individuals that write checks to pay bills for personnel costs, tax withholding, worker's compensation, health insurance and other taxes and benefits appropriate for the specific provider consistent with the individual's and families ISP or budget for services. The Financial Management service provider or fiscal intermediary serves at the request of the county and is made available to the participant/family to insure that appropriate compensation is paid to providers of services. Includes paying bills authorized by the participant or their guardian, keeping an account of disbursements and assisting the participant ensure that sufficient funds are available for needs. This service is necessary to prevent institutionalization. Excludes payments to court appointed guardians or court appointed representative payees if the court has directed them to perform this any of these functions.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. The Financial Management Services provider must have a contractual relationship with the county that specifies the scope of services, payment rates for all providers and other policy directives that the intermediary must follow.

2. The Financial Management Services provider is accountable for insuring compliance with all federal and state laws associated with tax withholding and all other employee benefits.

3. The Financial Management Services provider must be subject to an audit to ensure all transactions have been properly executed.

STANDARDS

1. Providers must be an agency, unit of an agency or individual that is qualified to provide all of the financial services involved. Providers must have training and experience in accounting or bookkeeping.

2. The Financial Management Services provider must be bonded.

3. The provider must retain all documents and records for seven years as required by law and regulation. Records shall be organized so that individual service expenses are easily understood by lay people.

4. Providers should be capable of communicating with Waiver participants/ family members and are expected to promptly respond to questions about the participant's financial position relative to service expenditure at any given point in time.

5. The Financial Management Services provider shall have a system in place, which recognizes the participant or their legally authorized representative as the agent required to initiate payment for any provider/service.

6. The fiscal intermediary shall have a system in place which addresses :
   a) response rate to participant requests;
   b) capacity to promptly issue payroll or other funds in emergency situations; and
   c) assure and communicate about the accuracy of payments made.

7. The fiscal intermediary shall comply with HFS 92 rules and all other applicable laws and rules governing confidentiality.

8. Provider Screening Requirements: All persons who provide this service shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of these services such as misappropriation of participant funds shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

DOCUMENTATION

1. The County shall have documentation on file that indicates the provider is qualified.

2. The provider shall keep records of all transactions associated with paying providers in an accessible location available for state or county inspection on short notice.

HOME DELIVERED MEALS

SPC 402

DEFINITION

The provision of meals delivered to the home of the participant. Persons who need this service are generally persons who are at risk of institutionalization due to inadequate nutrition. Home delivered meals costs include the purchase and planning of food, supplies, equipment and labor, as well as the transportation costs associated with the delivery of the meal. The service may include one or two meals per day delivered to the participant's home. Participants provided with home delivered meals may be unable to plan, prepare or obtain nutritional meals without assistance or may be unable to manage a special diet recommended by their physician.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Home delivered meals must be delivered to the participant in his or her own home.

2. Excludes meals provided by or in an adult family home, children's foster home or any other substitute care setting or at any day or vocational provider.

3. Excludes the retail purchase of commercially available frozen meals, or nutritional supplements (e.g. Ensure).

4. Includes the purchase of prepared frozen meals from the home delivered meal vendor, for use by the participant on those days that home delivered meals are not available.

5. More than one home delivered meal provider may be used to meet the participant's need.

6. Provider Screening Requirements: All persons who transport meals to the participant's residence shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

7. Providers must communicate with county staff and other providers within confidentiality laws any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9.

STANDARDS

1. Home delivered meal providers must be a licensed food service provider, an Older American's Act program providers or meet the standards of one of these providers.

Licensed food service providers include restaurants, nursing facilities, hospitals, public schools and other providers that are licensed by the state or a local government to prepare and serve food. Older American's Act programs and licensed providers must comply with Wisconsin Statutes 254 and HFS 196. Hospitals that provide home delivered meals must comply with HFS 124. Nursing facilities that provide these meals must comply with HFS 132.

2. Meals purchased must assure adequate nutrition and must contribute to meeting the daily dietary needs of the participant receiving the meal.

3. Specially prepared meals, necessary to meet unusual dietary requirements or restrictions may be reimbursed, provided the cost of these meals is the same as that charged to persons who are not Waiver program participants (usual and customary).

DOCUMENTATION

Evidence that the provider(s) of this service comply with the requirements of this service must be in the participant's file or in a file at the county agency readily accessible for state review.

HOME MODIFICATIONS

SPC 112.56

DEFINITION

Home modifications are additions or alterations to a participant's residence that address needs associated with accessibility, health, safety, security or that allow the participant the maximum degree of independence in and around their home in the community. Home modifications may include materials and services needed to assess the need for the modifications, needed to actually construct any covered modification or needed to maintain or repair the modification. A Home modification may be covered if the modification addresses the accessibility, health, safety, security and independent functioning needs of the participant. The following is an illustrative list of items typically covered under this service so long as they address the needs noted in this definition:

1. Ramps/turnaround space
2. Lifts
   a. Porch or stair lifts
   b. Hydraulic, manual or other electronic lifts
3. Modifications/additions of bathroom facilities
   a. Roll-in showers
   b. Sink modifications
   c. Bathtub modifications
   d. Toilet modifications
   e. Water faucet controls
   f. Floor urinal and bidet adaptations
   g. Plumbing modifications
   h. Turnaround space adaptations
4. Modifications/additions of kitchen facilities
   a. Sink modifications
   b. Sink cut-outs
   c. Turnaround space adaptations
   d. Water faucet controls
   e. Plumbing modifications/additions
   f. Worktable/work surface adjustments/additions
   g. Cabinetry adjustments/additions
5. Specialized accessibility/safety adaptations/additions
   a. Door-widening/hall widening
   b. Wall protection
   c. Floor adaptations
   d. Electrical wiring
   e. Grab bars and handrails
   f. Automatic door openers/doorbells
   g. Voice activated, light activated, motion activated and electronic devices

h. Fire safety adaptations
i. Medically necessary air filtering devices
j. Medically necessary heating/cooling devices and services
k. Basement remodeling including adding exits and other covered modifications
l. Fences to yards that increase the participant's safety and permit the participant greater access to the home environment
m. New construction that may involve added space to the home if specific criteria are met.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. Prior approval of all home modifications costing more than $1,000 must be obtained from designated state staff or representatives. Approval may be done as part of the initial service plan approval process, via the submission of a revised and update ISP with this service funded at a level exceeding the $1000 limit included or via a separate request.

2. Home modifications shall be directly related to the participant's accessibility, health, safety or security needs or enhance the participant's independent functioning.

3. No Waiver funds may be expended for home modifications if the Medicaid State Plan can cover the modifications.

4. General structural repairs to the house necessary to maintain habitability shall not be included as home modifications unless the damage to be repaired is a direct result of some aspect of the participant's disability (such as broken windows or damaged walls due to challenging behavior). Waiver participants may not be required to pay for repairs that are directly attributable to challenging behavior or some other aspect of the person's disability.

5. Includes repairs and maintenance to and reasonable replacement of an approved home modification if specified in the Individual Service Plan.

6. Home modifications generally exclude new construction that adds rooms or interior space to the dwelling unless the modification addresses one or more of the criteria listed below and is not inconsistent with the others:

   a. There must be no other feasible or reasonable way to provide the participant with a needed adaptation/modification without adding a room or additional interior space to the dwelling. For example, if the only way to create an accessible bathroom would mean that the house would lose its only living room, this would be considered unreasonable and meet this criteria.
   b. The adaptation in question must be related to accessibility, health, safety or security needs or enhance the participant's independent functioning and help maintain the person in the community and prevent institutionalization.

c. The addition of space associated with the modification/adaptation must be cost effective compared to other modification options that do not require the addition of space to the dwelling.
d. The modification provides for the participant's safety in the residence or enhances the person's mobility and/or caregiver's ability to properly assist the person.

If there is no way of modifying existing space and space is planned to be added for the program participant, the need for adding additional space must be verified by a qualified building professional with expertise in accessibility or one of the Centers for Independent Living. All modifications that involve the addition of interior space must be separately requested by the county, are accompanied by documentation that all requirements are met and are subject to separate approval by the department.

7. The county agency must assure that all modifications were made in accordance with applicable state and local building codes.

STANDARDS

1. All providers used in the construction or design process must meet any state or local licensure or certification requirements for building contractors, plumbers, electricians, engineers, or other construction jobs.

2. All modifications, improvements or repairs must be made in accordance with local and state housing and building codes and are subject to any inspections required by the municipality responsible for administration of the state or local building code.

DOCUMENTATION

1. Home modifications must be included in the Individual Service Plan.

2. If the cost of the modification is greater than $1000, documentation of approval by the Department must be included in the participant's file.

3. If the modification involves the addition of square footage, there must be documentation that all criteria have been met and that the modification has been approved by the department.

4. For modifications involving the addition of space, the case manager's written request to the department, the rationale for the request, the contractors estimate of the proposed modifications and verification that additional space is the best option for making the home accessible and the guardian's approval of the modification (which may simply be on the ISP) must be in the participant's file. The participant's file shall also contain the department's approval.

5. For modifications that can be covered by the Medicaid State Plan, a written denial from appropriate DHFS staff or their agents must be in the case file before expending Waiver funds.

6. A professional' s expertise in accessibility and their written finding that adding space to the dwelling is needed should both be placed in the individual's county file.

HOUSING COUNSELING

SPC 610

DEFINITION

The provision of services to Waiver participants to provide people with comprehensive guidance on housing opportunities that are available to meet their needs and preferences. Includes guidance on how a participant may gain access to available public and private resources available to assist the person obtain or retain safe, decent, accessible, and affordable housing and avoid institutionalization. Housing Counseling includes planning, guidance and assistance in accessing resources related to:

1. Home ownership, both pre and post purchase
2. Home financing and refinancing
3. Home maintenance, repair and improvements including abating environmental hazards;
4. Rental Assistance Guidance but not including any cash assistance;
5. Accessibility and architectural services and consultation
6. Weatherization evaluation and assistance in accessing these services
7. Lead base paint abatement evaluation and services
8. Low income energy assistance evaluation
9. Eviction prevention
10. Access to transitional or permanent housing
11. Accessibility inventory design
12. Health and safety evaluations of physical property
13. Debt/credit counseling
14. Homelessness Prevention

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. A qualified provider must be an agency or unit of an agency that provides Housing Counseling as a regular part of its mission.

2. Counseling must be provided by staff with specialized training and experience in any of the housing issues listed in the definition of this service.

3. This service shall be available to anyone in the general public who needs assistance with any of the housing issues addressed by the definition of this service. Person's using this service or third parties shall be charged for the service using a methodology consistent with the one used to establish provider reimbursement rates for Waiver participants.

4. Excludes reimbursement if this service is provided by an agency that also provides residential support services or support/service coordination to the Waiver participant.

5. Excludes funding for physical alterations of a person's home to address accessibility. These are included under Home Modifications.

6. Excludes funds to pay for items necessary housing start up expenses. These may be covered under the service "Housing Start-up."

STANDARDS

Persons or agencies providing Housing Counseling must have expertise in housing issues relevant to the Waiver participant and their needs as identified in the Individual Service Plan.

DOCUMENTATION

The County shall have documentation on file that indicates the provider is qualified.

HOUSING START UP

SPC 106.03

DEFINITION

The provision of services and essential items needed to establish a community living arrangement for persons who are relocating from an institution or who are moving from a family home to establish an independent living arrangement. Includes person-specific services, supports or goods that will be put in place in preparation for the participant's relocation to a safe, accessible, affordable community living arrangement.

SERVICE REQUIREMENTS/EXCLUSIONS/LIMITATIONS

1. Allowable services or items covered by this service may not be purchased more than 180 days prior to the date the participant relocates from the facility in which the person currently resides per the allowable cost manual provision on start up costs.

2. Includes purchase of necessary furniture, kitchen appliances not furnished by the landlord in the housing arrangement, telephone(s), cooking/serving utensils, basic cleaning equipment, household supplies and bathroom and bedroom furnishings.

3. Housing start up services may include the payment of a security deposit, heating/electric/water utility connection costs and telephone installation charges.

4. Excludes home modifications necessary to address safety and accessibility in the person's living arrangement. These must be classified under that service.

5. Includes payments for moving the participant's personal belongings to their new community living arrangement and services needed to prepare the selected community living arrangement for occupancy. This preparation activity may include general cleaning and the organization of the household.

6. Excludes the purchase of food, the payment of rent, or the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service, etc.)

STANDARDS

1. Furnishings and equipment purchased must be in good condition and in safe, working order.

2. Persons hired to prepare the household for occupancy or moving the participant shall meet the standards for shall meet the standards for supportive home care providers that provide household services.

DOCUMENTATION

1. County agencies shall document all payments made under this service.

2. County agencies shall document in the participant record or in an accessible location within the agency verifying that the providers of housing preparation or moving services meet supportive home care requirements.

3. Each service or item provided under housing start up must be listed separately on the ISP summary and described in the narrative.

INTENSIVE IN-HOME TREATMENT FOR CHILDREN WITH AUTISM, ASPERGER'S AND PERVASIVE DEVELOPMENTAL DISORDERS

SPC 512

DEFINITION

The provision of treatment oriented behavioral services provided by qualified professionals to children diagnosed with Autistic Disorder, Asperger's Disorder and Pervasive Developmental Disorders (NOS) and their families. This service may consist of a variety of therapeutic approaches that can be implemented with the intent to enhance behavior, communication, and social skills. The intent of the treatment is to develop and improve health, welfare, and effective functioning in the home and community.

Any service provided may not also be covered under the Medicaid State Plan.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Only those services not reimbursable under the State Medicaid Plan will be reimbursable using Waiver funds.

2. The cost of travel time may be included in the rate paid to the provider of this service.

3. Any treatment that is to be funded by the Waiver program must be directly related to an individual child's therapeutic goals.

4. A variety of behaviorally based therapy models consistent with best practice and research on effectiveness will be permitted under this Waiver.

5. This service is limited to children who, through an independent evaluation, meet the required diagnostic and functional criteria before starting services.

6. Services must start before the child reaches age 8 years, unless a variance has been granted by the Department of Health and Family Services.

7. Intensive levels of services are defined as a range of 20 to 35 hours of face-to-face contacts per week. Individual plan hours may vary. Individual hours are established by discussions with the child's team including, providers, the child's family, and the county.

8. Services are provided on a face-to-face basis with the child.

9. Once children have had three years of intensive services, or at such time that they are not making progress towards outcomes at the intensive level of service, they will transition to other home and community-based services Waiver supports and services. Variances to this

three year-limit may be requested and are subject to the approval of the Department of Health and Family Services

10. Intensive services must be coordinated with other relevant services, such as educational services through the public schools; Medicaid card covered services, and private supports and services.

11. The use of intensive in-home autism is exclusive of the other home and community-based services Waiver services.

STANDARDS

PERSONNEL

A. TEAM COMPOSITION

The In-home intensive treatment team consists of:

1. Lead therapist:

A provider who has the following credentials and experience MUST lead the in-home intensive treatment team. The lead therapist must present written evidence of the following requirements, prior to the provision of services:

a. A doctoral degree in psychology, or a medical degree from an accredited educational institution;

b. Actively licensed by a state board of examiners of psychiatry or is a licensed psychologist who is listed or eligible to be listed in the National Register of Health Care Providers in Psychology;

c. Has completed 1500 hours of training or supervised experience in the application of behaviorally based therapy models consistent with best practice and research on effectiveness, for children with an autistic disorder, Asperger's disorder or pervasive developmental disorder (NOS); and

d. At least two years of experience as an independent practitioner, and as a supervisor of less experienced clinicians.

2. Senior therapist:

   a. The senior therapist must be a certified psychotherapy provider, with a master's degree in one of the behavioral sciences who has at least 400 hours of training or supervised experience in the use of behaviorally based therapy models consistent with best practice and research on effectiveness, for children with Autistic Disorder, Asperger's Disorder or Pervasive Developmental Disorder (NOS); in addition to, or as part of their 3000 hours of training/supervision; OR

   b. A bachelor's degree in a human services discipline and at least 2,000 hours of training or supervised experience in the use of behaviorally based therapy models consistent with best practice and research on effectiveness, for children with Autistic Disorder, Asperger's Disorder or Pervasive Developmental Disorder (NOS).

3. Line staff:

   a. Line staff must be at least 18 years old and a high school graduate.

   b. Line staff must have obtained at least 30 hours of direct supervised experience in the use of behaviorally based therapy models consistent with best practice and research on effectiveness, for children with Autistic Disorder, Asperger's Disorder or Pervasive Developmental Disorder (NOS); OR have at least 160 hours working in any setting with children with Autism Spectrum Disorders prior to the provision of services.

   c. The lead therapist and the child's family will recruit all staff with careful consideration given to background checks and compatibility.

   d. Line staff must work under the direction of the lead therapist and the senior therapist.

   e. Line staff must be oriented to the specific outcomes and approach for provision of services for an individual child.

   f. Line staff must be directly supervised during their initial visit with a child.

B. TEAM ROLES

The lead therapist assesses the child and develops the intensive treatment plan based upon the child's individual needs. The senior therapist then provides the ongoing supervision of the implementation of the treatment plan, this includes training and supervision of the line staff, training for the family and weekly team meetings to review the child's progress and develop an intervention plan for the next week. Line staff implement the discrete trials. Families also follow through on discrete trial activities, although these hours are not billable to the Waiver. The lead therapist monitors progress on at least a monthly basis and more frequently if needed to address issues with the child's outcomes.

Discrete trials are an operant conditioning technique which includes the introduction of a particular activity with a specific desired outcome for a child. The child receives positive reinforcement for properly completing the task.

1. Lead therapist:

   On teams with a senior therapist: Following the initial training session, the lead therapist trains and directs the team by conferring with the Senior Therapist at least weekly in person or by telephone and by working with the child in person and with the Senior Therapist and one or more line staff at least every two months.

   On teams without a senior therapist: Following the initial training session, the lead therapist trains and directs the team by working with the child in the home and the line staff at least weekly.

2. Senior therapist:

   The senior therapist is an extension of the lead therapist and works with the child, the child's family, and other team members in the home a minimum of two hours weekly. The senior therapist confers with the lead therapist at least weekly in person or by telephone and implements any changes in the treatment plan that might result from the conference; and, works with the child, the child's family, and line staff to assure that the treatment plan is being followed accurately.

3. Line staff:

   Line staff are trained by the lead therapist and senior therapist and directly supervised by the senior therapist and/or lead therapist to implement the treatment plan. The lead therapist is responsible to assure that line staff follow the treatment plan and provide good quality safe care. The line staff documents the nature and scope of the services, as directed by the lead therapist and/or senior therapist, provided during each session with the child.

   Line staff may accompany children to community-based activities that are intended to facilitate generalization of the behavior principles being covered in the in-home

sessions and/or as transition to school, day care, and other community settings. Community-based activities without therapeutic intent are not covered; therefore, any community-based activities must be clearly documented with purpose, time spent and measurable goals in the individualized treatment plan of the child.

4. Family involvement:

The families of children receiving intensive in-home services are vital members of the in-home autism therapy team. They must be involved in the initial training session to initiate in-home intensive therapy, and must remain involved with the team so that they are able to carry through and reinforce the behaviors being worked on by the therapy team. The parents need not be available for all therapy sessions but must be present at team meetings and workshop sessions.

DOCUMENTATION

1. The lead therapist shall provide a written progress report to the child's service coordinator and family at least every six months.

2. All of the services provided must be clearly documented in the child's chart by one of the team members present. Documentation must include location of service, time spent and team members present.

3. For billing purposes, the provider records must support, in case notes, time logs or other forms of documentation, the units of service billed.

NURSING SERVICES

SPC 710

DEFINITION

Nursing Services are those medically necessary, skilled nursing services that may only be provided safely and effectively by a Nurse Practitioner, a Registered Nurse, or a Licensed Practical Nurse working under the supervision of a Registered Nurse. The nursing services provided must be within the scope of the Wisconsin Nurse Practice Act and not otherwise available to the participant under the Medicaid State Plan. Nursing services may include periodic assessment of the participant's medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or to monitor and/or modify the medical treatment services provided by non-professional care providers. Services may also include regular, ongoing monitoring of a participant's fragile or complex medical condition as well as the monitoring of a participant with a history of non-compliance with medication or other medical treatment needs.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes skilled nursing care that can be covered by the Medicaid State Plan. A denial of coverage by the state plan is required. Medicaid State Plan nursing services may include assessments necessary due to an unstable condition; the potential onset of an acute episode, medical complications, adverse reactions to prescribed medication, teaching and training of a participant or non-professional caregiver, as well as skilled medical procedures identified in the Medicaid Provider Handbook. Medicaid covered nursing services generally require prior approval. Necessary nursing services that exceed the total services authorized by Medicaid or that have been denied Medicaid coverage may be covered by the Waiver program.

2. Nursing services must be provided by a Nurse Practitioner or a Registered Nurse. A Licensed Practical Nurse may provide services under the supervision of a Registered Nurse, licensed to practice in Wisconsin.

3. The need for skilled nursing services must be recommended or prescribed by the participant's physician and reviewed by the care manager.

4. Includes Private Duty Nursing as defined by the Medicaid State Plan if coverage by the state plan was denied.

5. Excludes consultation provided by a Registered Nurse to an interdisciplinary team, including participation in the assessment and care plan development process. These activities should be classified under Support and Service Coordination under SPC 604.

6. Provider Screening Requirements: All persons providing this service shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the

caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. Section 1.05 of Chapter IV of the Medicaid Waivers Manual details this requirement.

7. All providers must communicate with designated county staff and other providers within the limits of confidentiality laws and rules about critical incidents as defined in the Medicaid Waivers Manual, Chapter 9.

STANDARDS

Providers shall conform to Wisconsin Statutes s. 441 (Board of Nursing) regarding licensing and accreditation shall apply.

DOCUMENTATION

1. The participant file must contain documentation of a denial of coverage by the Medicaid State plan for services covered by the Waiver and the reasons that the covered nursing services could not be obtained through the Medicaid State Plan.

2. The participant file must contain documentation that the provider of nursing services is Registered Nurse, a Nurse Practitioner or a Licensed Practical Nurse working under the supervision of a Registered Nurse.

PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

SPC 112.46

DEFINITION

Personal emergency response systems are the provision of systems that provides immediate assistance in the event of a physical, emotional or environmental emergency through a community-based electronic communications device. This service can provide a direct link to health professionals to secure immediate assistance by the activation of an electronic communications unit in the consumer's home.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Only those emergency response systems that cannot be obtained through Wisconsin's approved Medicaid State Plan will be paid for with Waiver funds.

2. Costs associated with telephone line installation and the adaptation of such lines and line connections already in place in the residence are allowable, if they are necessary to attach or operate the Personal Emergency Response System.

STANDARDS

These devices, where applicable, must meet Federal Communications Commission standards or Underwriter's Laboratory standards or equivalent standards.

DOCUMENTATION

1. The necessity for this type of emergency safety measure to prevent institutionalization must be described in the Waiver participant's Individual Service Plan packet.

2. The choice of PERS as a cost-effective method of meeting the need for safety and security must be outlined on the Individual Service Plan.

PRE-VOCATIONAL SERVICES

SPC 108

DEFINITION

Pre-vocational services are the provision of services to teach an individual the skills necessary to succeed in employment. Services occur over a defined period of time and involve training and the provision of opportunities for experiences that enhance basic work-related skills. Training is intended to teach an individual concepts necessary to effectively perform a job in the community and may include following directions, attending to tasks, task completion, appropriate responses to supervisors/co-workers, attendance/punctuality, problem solving, safety and mobility training. Work-related skills include reporting to work on time, taking proper sanitary measures, wearing appropriate clothing, acting in a manner that is appropriate to the situation and other skills necessary for successful employment. Services include supervision and training. The focus is on general habilitative rather than specific employment goals.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Prevocational Services do not include services available as defined in S4(a) (4) of the 1975 Amendments to the Education of the Handicapped Act (20 U.S.C. 1401(16),(17) which otherwise are available to the individual through a State or local educational agency and vocational rehabilitation services which are otherwise available to the individual through a program funded under S110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

2. Participant's with measured productivity higher than 50% of the industrial standard for their jobs may not start a program of Prevocational Services.

3. If, after receiving this service, a participant's productivity rises above 50% of the industrial standard for their job, the participant will be permitted to continue to receive this service funded by the Waiver only if the following conditions are met:

   (1) There is written documentation that the participant was given the informed choice indicating they can receive Supported Employment Services,
   (2) The county indicates in the informed choice communication that any funds currently being used to pay for the Prevocational Services will be available to the participant so the participant can access Supported Employment Services promptly; and
   (3) If a participant requests a Supported Employment assessment, a DVR funded assessment will be arranged and provided.

4. Services must be reflected in the person's vocational plan and must focus on general work skills rather than specific employment objectives.

5. Vocational counseling must be provided as needed. (DVR Technical Specifications are used as guidelines.)

6. Transportation may be provided, if needed between the participant's place of residence and the site of the Prevocational Services or between sites in cases where the participant receives Prevocational Services in more than one place or as a component of Prevocational Services. The cost of this transportation may be included in either the rate paid to the Prevocational Service provider or to the transportation provider under Specialized Transportation.

7. Provider Screening Requirements: All persons providing this service shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

8. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9.

STANDARDS

1. Minimally, a Vocational Service Plan is required to address the following:

   a. establishes each participant's rate of pay and any anticipated wages;

   b. focuses on and describes general habilitative objectives and clearly indicates the specific prevocational activities that the participant will engage in;

   c. provides the rationale as to why the participant is not expected to join the general work force, or participate in supported employment within a year; and

   d. addresses what the participant needs to do to participate in supported employment.

2. Services must be reviewed semi-annually to determine if progress is being made toward achieving goals and if prevocational services remain the most appropriate for the participant.

3. Providers that are accredited by the Rehabilitation Accreditation Commission (CARF) are deemed to have met the standards for this service. Providers not accredited by CARF must meet the standards and requirements of this service.

4. PERSONNEL. There shall be a direct service staff person or persons who shall possess skills and knowledge that typically would be acquired through:

   a. A course of study that would lead to a bachelor's degree in one of the human services, or
   b. A minimum of 2 years of academic, technical or vocational training consistent with the type of work to be supervised or

c. A minimum of 2 years experience in a work situation related to the type of work supervised.
d. Additional staff or consultants who are knowledgeable and skilled in adapting or modifying equipment and environments, and the application of special equipment for persons with physical disabilities shall be available, as needed.
e. Agencies offering Prevocational Services shall maintain the following staff ratios when the program is operating:

1. There shall be a minimum of 2 direct service staff for the first 15 people receiving Prevocational Services.
2. The actual ratio of staff to program participant shall reflect the specific needs of the individuals being served. A ratio reflecting the needs of the specific participants served shall be provided.

5. PROGRAM. Prevocational Services shall include remunerative work including supervision and instruction in work tasks and observance of safety principles in a realistic work atmosphere. A realistic work atmosphere is most effectively provided within a community job site setting, whenever possible.

a. Work orientation shall be provided to encourage good work habits. It shall include proper care of equipment and materials, correct handling of tools and machines, good attendance, punctuality, and safe work practices. It shall afford a work pace consistent with the participant's potential.

b. The layout of work positions and the assignment of operations shall ensure the efficient flow of work and appropriate relationship of each operation to all other operations in its sequence with respect to the time required for its completion. The organization of work shall embody awareness of safe practices and of the importance of time and motion economy in relation to the needs of individuals being served.

c. Information concerning health and special work considerations of participants should be taken into account and shall be clearly communicated in writing to supervisory personnel.

d. Vocational counseling shall be available.

1. The agency offering Prevocational Services, shall maintain provisions either within its parent organization or through cooperative agreements with the Division of Vocational Rehabilitation or other job placing agencies, for the placement in regular industry of any of its individuals who may qualify for such placement. Individuals shall be informed of the availability of such services for placement in competitive industry.

2. The agency offering Prevocational Services shall maintain payroll sub-minimum wage certificates and other records for each participant employed in compliance with the Fair Labor Standards Act.

3. The agency offering Prevocational Services shall provide the participant with effective and accessible grievance and complaint procedures.

4. Prevocational Services shall be provided as recommended in the individual service plan.

5. Appointed staff supervising the Prevocational Services shall send a written report to the Support/Service Coordinator at least every six months. The report shall contain a statement on progress toward the goals and objectives of the participant service plan and the recommendations for changes.

6. If the participant receiving Prevocational Services displays challenging needs, a positive written behavior support plan must be developed and implemented to assist the participant.

DOCUMENTATION

1. County or contract agency must be able to provide documentation verifying that the provider and personnel meet the standards in this section. County agencies may choose to include a provision in contracts or provider agreements with provider agencies requiring that the personnel and program meet standards.

2. The Vocational Service Plan must include the following information:

   a. Documentation of each participant's rate of pay and wages;

   b. Documentation indicating that the intent of the program is not directed toward a specific job skill;

   c. A description of services which focuses on general habilitative rather than specific employment objectives;

   d. A description of the specific prevocational activities that the participant will be engaged in, and

   e. Written rationale as to why the participant is not expected to join the general work force, or participate in Supported Employment, within a year and a statement addressing what the participant would need to do to participate in supported employment.

3. The agency offering Prevocational Services shall maintain payroll, sub-minimum wage certificates in compliance with the Fair Labor Standards Act.

4. The agency, when appropriate, will report participant's wages to Social Security.

5. The agency offering Prevocational Services shall provide the participant with effective grievance procedures that link to the county's process under HFS 94.

6. If separate transportation is provided, the cost of transportation must be clearly identified separately from other Prevocational Services.

7. The county must maintain documentation that a semi-annual review has been done that addresses progress toward prevocational objectives, reasons why Prevocational Services remain appropriate, and recommendations for any changes.

8. There shall be documentation of current and up to date criminal and caregiver background checks in the participant's or a provider file on all persons providing services and supports to any Waiver participant.

RESPITE CARE

SPC 103.22 -Residential Respite Care
SPC 103.24 -Institutional Respite Care
SPC 103.26 - Home-based Respite Care
SPC 103.99 -Other Respite Care

DEFINITION

Respite Care is the provision of short-term services to Waiver participants, in one of a number of different settings. Services are provided to the participant and are also intended to benefit the participant's family and/or other primary caregiver(s). Respite care provided in regulated residential settings is called "*Residential Respite Care*." The allowed regulated settings include licensed or certified Adult Family Homes, Children's Foster Homes including treatment foster homes, Community Based Residential Facilities (size limit of 8 applies) or Children's Group Homes. Respite care that is provided in a certified Medicaid funded institutional setting is called "*Institutional Respite Care*." The allowed institutional settings include hospitals, nursing homes or Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). Respite care that is provided in the participant's own home is called "*Home-based Respite Care*." Respite care provided outside the participant's home, in the home of someone unrelated to the participant where the setting is not licensed or certified by the state or county agencies or, for children, in a licensed or certified child day care setting is called "*Respite Care- Other*."

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Institutional Respite Care requires prior approval by the Department, except in emergency situations. "Emergency situations" are any situations where the regular caregiver suddenly and unexpectedly becomes unable to provide care due to death, illness, disability or other unanticipated reasons. Emergency situations also include an emergency detention under the authority of Chapter 55 Wisconsin Statutes. Requests for approval of this type of Respite Care must include the rationale for the use of respite in such settings. This explanation must include:
   a. The reason for the request.
   b. The anticipated length of placement.
   c. A description of the barriers to using other available community-based services.
   d. A description of the proposed service.
   e. An estimate of the anticipated length of stay.

   Institutional Respite Care may not be used to fill gaps in the participant's service plan due to worker shortages or other home care shortfalls.

2. The settings used in residential and institutional respite care shall be properly licensed or certified according to the standards applied to these facilities and be in good standing with the licensing or certification authority. Child day care settings used for respite care must licensed under state standards.

3. If a CBRF or Group home for Children is used for respite care, the licensed capacity may not exceed 8 beds. Children's group homes are otherwise not an allowed living arrangement for Waiver participants.

4. Respite Care services of any kind are not intended to meet the needs of persons who are temporarily without a permanent living arrangement. The use of this service for such individuals is not permitted.

5. Room and Board costs may be funded by the Waiver under both Residential Respite Care and Institutional Respite Care.

6. Room and Board costs may not be funded by the Waiver in Home-based respite or when respite occurs in the home of someone other than the participant or a relative in a setting not regulated by the department or county agencies.

7. Provider Screening Requirements: All persons who provide this service shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of these services such as misappropriation of participant funds shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

8. All Respite Care providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9.

STANDARDS

Residential Respite

The home or facility must meet provider standards in this chapter required of the type of provider used. This may include a certified or licensed Adult Family Home, a licensed Community Based Residential Facility, a Children's Foster Home including a Treatment Foster Home and a Children's Group Home.

Institutional Respite Care

The facility must be a Medicaid certified hospital, nursing home, or an Intermediate Care Facility for the Mentally Retarded (ICF-MR). The Institutional Respite facility must have a current provider agreement with the Medicaid Program.

Home-based Respite Care

All persons who provide respite care in the participant's home must meet the all of the provider Standards applied to staff who provide Supportive Home Care.

Respite Care- Other

1. When Respite Care is provided in a private home other than the participant's and the setting is not licensed by the department or certified by a county agency, the home shall meet standards for "The Home" in Section 05, of the standards for 1-2 Bed Adult Family Homes.

2. When Respite Care is provided to a child in a family day care setting or in a day care center for children, it must be licensed under HFS 55, Licensing Rules for Group Day Care Centers or Family Day Care.

3. All persons who provide respite care outside the home of the participant in the home of someone who is not a relative shall meet the all of the provider standards applied to Supportive Home Care. The service requirements, limitations and exclusions for supportive home care also apply.

DOCUMENTATION

1. Regulated Residential Respite Care providers must have current licensure or certification under the applicable statutes, administrative codes or Chapter 4, 3.10 (103) of the Medicaid Waivers Manual. These include HFS 83 for CBRFs; HFS 82 and HFS 88 for 3 or 4 bed Adult Family Homes, The Standards for 1 - 2 bed Adult Family Homes contained in this manual, HFS 56 for Children's Foster Homes, HFS-38 for Children's Treatment Foster Homes, and HFS 57, Group Homes for Children.

2. Providers of Home-based Respite care and Respite Care- Other shall document they meet the standards applied to them in this section. This documentation shall be in the file of each participant served.

3. Institutional Respite providers must have current Medicaid certification and a current provider agreement with the Medicaid Program and documentation to verify this.

SPECIALIZED MEDICAL & THERAPEUTIC SUPPLIES

SPC 112.55

DEFINITION

The provision of items and devices necessary to maintain the participant's health, manage a medical or physical condition, improve functioning or enhance independence. Items or devices provided may be in excess of the quantity of medical equipment and supplies covered under the Medicaid State Plan when the prior approval of additional items or devices has been denied. Items or devices needed must be of direct medical or remedial benefit to the participant.

The following are the categories of therapeutic items or devices that may be included in this service: nutritional supplements, skin lubricants recommended or prescribed by a physician or professional, therapy aids, incontinence materials, wound dressings, enema administration apparatus, IV or life support equipment, over the counter medications and books and literature relevant to the participant's medical condition.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Includes supplies, items or devices that have a medicinal purpose.

2. Medical supplies purchased in excess if the quantity furnished under the Medicaid state plan require documentation indicating that the state plan limit has been reached or prior authorization for additional items has been denied.

3. Allowable specialized medical and therapeutic supplies must be ordered or prescribed by the participant's physician or other professional.

4. Medication set up charges are a Medicaid State Plan-covered service and may not be billed to this service.

5. Medicaid Waiver funds may not be used to purchase experimental items or devices.

6. The cost of installation and servicing or replacing any allowable specialized medical or therapeutic supply is covered under this service.

STANDARDS

All items and supplies shall meet applicable standards of manufacture, design, installation, safety and treatment efficacy.

DOCUMENTATION

1. Documentation of a denial of prior authorization or that limits have been reached must be in the participant's file for supplies covered by the Medicaid State Plan.

2. The participant's record must contain documentation about the medical or remedial benefit of the supply or item to the participant.

3. The written order, prescription or recommendation from the physician or professional must be present in the participant's record for all items and devices purchased under this service. Examples of acceptable documentation include copies of an order or prescription or a case note verifying a contact between the care manager and the medical professional regarding the medical necessity of the items or supplies to be purchased.

4. A description of each item or device covered by the Waiver must be included on the participant's individual service plan.

SPECIALIZED TRANSPORTATION

SPC 107.30 Trips
SPC 107.40 Miles

DEFINITION

Specialized Transportation is the provision of services to permit Waiver participants access to destinations in the community to obtain services, use needed community resources, and participate in community life. Specialized Transportation Services may consist of material benefits such as tickets or other fare medium or a payment covering all costs associated with the conveyance of program participants and their attendants. Specialized transportation services include those services that assist in improving the person's general mobility in the community, increase independence and participation and prevent institutionalization. Payments for this service may be based on the provider's cost of operating the vehicle and driver costs and may be charged on a per trip or per mile basis.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Specialized Transportation may include conveyances that provide access to other human services including those covered by the Medicaid Waiver as long as the cost for such transportation is excluded from those other services.

2. Transportation must be provided by public carriers, persons employed by commercial providers or by private volunteer drivers.

3. Provider Screening Requirements: All drivers employed by a commercial provider who provide this service shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of these services such as misappropriation of participant funds shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual. This provision excludes employees of public transit agencies and volunteer drivers who are not paid for the service but who may be reimbursed for the cost of using their own vehicle.

4. Payment for medical transportation that would otherwise be covered under the state Medicaid plan may be allowed when Medicaid-funded transportation is unavailable. "Unavailable" means that the ride could not be booked due to lack of capacity or the provider is unable to provide the trip. "Unavailable" is not a Medicaid denial.

5. Includes additional travel costs, if any, that may be charged by the provider, when an attendant or an informal unpaid caregiver accompanies the participant to assist them in

accessing or using the service. Excludes the costs of the attendant service itself, which may be covered under Supportive Home Care.

6. A fare or contribution to the cost of this service may not be collected per S. 49.49 (3M) WI Stats. if the participant's transportation is reimbursed as Specialized Transportation.

7. Providers must communicate with county staff and other providers within confidentiality laws any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9.

STANDARDS

1. Any provider transporting a Waiver participant shall hold an appropriate operator's license from the Department of Transportation.

2. Vehicles shall be in good repair with all operating and safety systems functioning properly. This includes lights, safety belts, tires, heaters and all mechanical systems needed to operate the vehicle.

DOCUMENTATION

1. The need for Specialized Transportation must be identified in the individual's assessment and on the individualized service plan.

2. The county agency must be able to document that the provider meets standards. The county agency may choose to include a statement in the provider contract or agreement requiring that the provider meet the standards for this service.

3. Documentation of current caregiver and criminal background checks of all private drivers used must be available and easily accessed upon request. This documentation may be in either each participant's county file or the county's provider files.

SUPPORT & SERVICE COORDINATION

(Formerly called Case Management)

SPC 604

DEFINITION

Support and Service Coordination is the provision of services to facilitate locating, connecting participants to, managing, coordinating and monitoring services and informal supports needed by Waiver participants and assure that services are provided in accordance with program requirements and assessed support needs. For children, services also include an assessment of family's needs so they may adequately support their child in their home. Services may also be directed at assisting connecting participants to natural supports. The intent of this service is to enable Waiver participants to receive a full range of appropriate services and supports consistent with their needs in a planned coordinated, efficient and effective manner. When provided to children, "Support and Service Coordination" facilitates the establishment and maintenance of the child and family's individualized support system.

Support and Service Coordination" includes assistance with establishing Medicaid financial and functional eligibility, assisting participants gain access to Waiver supports and services, Medicaid State Plan services, medical, social, and educational assessments and services, and any other services and resources, regardless of the funding source and to identify the supports necessary to insure the participant's health and safety. When provided to children, this service includes writing, coordinating, updating and assuring the effective implementation of the child and family's support plan and developing, implementing, and updating a family-centered transition plan and process including all necessary actors involved with the child.

Support and service coordination includes the following activities:

1. information and referral;

2. arranging for provision of services;

3. completion of level of care documents;

4. performing assessments;

5. service planning including person-centered planning;

6. referral assistance for participants to locate safe and appropriate housing;

7. monitoring Waiver services to assess participant progress towards meeting objectives and outcomes in service plans and assuring coordination between providers;

8. quality assurance and follow long activities to ensure participant health, safety and welfare;

9. crisis and critical incident intervention and resolution;

10. written and oral communications with participants, family members, guardians, providers, state staff and other members of the community;

11. When a prospective Waiver participant resides in an institutional setting, start up services may be provided up to 180 days prior to discharge. These services include service coordination activities, identification and connection of participants to providers and the development of the community resources identified as necessary to meet the participant's health and safety and support needs in the community

When provided for children:

12. participating in the initial screening and assessment;

13. transition planning process to facilitate entry into the adult system.

14. assuring the provision and quality of the supports identified in the child and family's support plan;

15. initiating and overseeing the process of assessment and reassessment of the individual's level of care;

16. reviewing plans of care and support plans at regular and appropriate intervals;

17. instructing the child and family how to independently obtain access to services and supports, regardless of funding source.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. This service focuses on all services and is not limited to only services funded by Medicaid Waivers.

2. Optional targeted case management under the Wisconsin State Medicaid Plan is not covered service to Waiver participants.

3. This service involves in-person and collateral contacts intended to ensure participant health, safety and welfare. If this service is not provided, county agencies must include a written description of how and by which providers or other natural supports the Waiver participant's health, safety and welfare will be assured. This description shall accompany the individualized service plan and all updates of the plan. The agency responsible for providing or purchasing Waiver services will be responsible for ensuring the provision of case management or alternate ways of ensuring health, safety and welfare for every individual served by the Waiver.

4. The Waiver agency must ensure that this service is provided by qualified personnel who meet the standards in this section.

5. The minimum requirements regarding the provision of support and service coordination are:
   a. Monthly collateral contact;
   b. face to face participant contact every three months;
   c. at least one of the face to face contacts under 5.b. of this section shall be at the participant's place of residence. A higher level of contact may be required as a condition of plan approval; and
   d. to assure health and safety, more frequent contact may be required in response to individual needs identified in assessments or prior critical incidents.

6. Direct contact with the participant includes written or email exchanges, telephone conversation or face to face contact. A collateral contact includes written or email exchange, telephone conversation or face to face contact with a participant's family member, medical or social service provider, or other person with knowledge of the participant's long term care needs.

7. When this service is provided to persons who participate in both a Medicaid certified Community Support Program (CSP) and a Medicaid Waiver program:
   a. The costs for the service may NOT be billed to the Waiver program.
   b. If the CSP service is provided to the Waiver participant in lieu of " Support and Service Coordination," it must also address all standards and requirements in this section, including minimum requirements regarding frequency of collateral and participant contact and documentation.
   c. The individualized service plan for any Waiver and CSP participant must specify the funding source for the CSP service.
   d. Counties are required to report units of services provided to a person participating in both the Waiver and CSP under SPC 604 even though no Waiver costs can be reported.

8. A criminal and caregiver background check must be provided for each person providing this service. Both types of background check must be repeated every fours years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

9. Support and service coordinators must communicate with the county's assigned State Community Integration Specialist staff any incidents or situations regarded as Critical Incidents as defined in Chapter 9.

10. At least every six months, the care manager shall review the plan of care during a face to face contact with the Waiver participant. No exceptions to this requirement are permitted.

11. It is anticipated that participants will require more contact than the minimum requirements above. On a few occasions, an exception to provide less than the minimum ongoing

monitoring contacts may be made. After the first six months of a participant's initial Waiver plan (unless the participant is already known to or has received services in the past from the case manager or lead agency) an exception to provide less than the minimum ongoing monitoring contacts may be made as a written request from the county. The county request must include:

(a) Evidence that the participant, or participant's guardian, requested a reduction in frequency of contacts; including the date the request was made and the reasons the participant or guardian gave for making the request.
(b) A plan that describes how health, safety and welfare will be assured without the required contacts.
(c) A description of the frequency, location and other characteristics of the contacts that will still be made.

No request for contact reduction will be approved if the participant or their guardian did not initiate the request. Requests originating from counties to address work load or other issues will not be approved.

Guardians shall be given the same written materials the county gives to the Community Integration Specialist (CIS). Both the county proposal and the CIS approval shall be in writing. Approval will be given on the basis of whether or not the proposal conforms to the following criteria:

i. The participant has lived in the community without a critical incident for three years. If the participant had experienced critical incident, if the likelihood of recurrence is low, this criterion may be waived.

ii. The participant is medically, socially, behaviorally and programmatically stable.

iii. The individual has an active and interested guardian or other natural supports that make regular contact with the participant and are knowledgeable of the participant's status. Active and interested in this context is defined as a guardian or other relationship with a person who regularly makes face to face visits with the individual not less than monthly and can adequately monitor the participant's status. These active and interested people should be able to be viewed as a reasonable substitute to the case manager for monitoring participant health, safety and welfare. Such individuals must also be familiar enough with the individuals' services and providers so they know who to contact when they have a question or concern regarding the individual

iv. The guardian is not also the participant's paid residential service provider or paid by the county for providing services. No variance is permitted if guardian is paid by the county.

v. The participant or guardian requested the variance.

Variances granted will have a time limit or will be in effect for no more than five years from the date of CIS approval in the approval letter. Regardless of the granting of a variance, the requirement for one or more home visits by the case manager or an approved agent of the county remains in force. No variance can be granted to eliminate this requirement.

STANDARDS

1. A support and service coordinator shall have skills and knowledge typically acquired:

   a. through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience in working with individuals of the specific target group for which they are employed to work; or through a minimum of four years experience as a long term support manager/coordinator; or
   b. through an equivalent combination of training and experience that equals four years.

2. The support and service coordinator shall be knowledgeable of the service delivery system needs of the target group being served, need for integrated services and resources available or needing to be developed.

3. Support and service coordinators must complete the BDDS Waiver Basics training course within six months of employment. Until completed, the coordinator must work under the direct supervision of a qualified support service coordinator who must review and sign off on all required processes.

4. Support/service coordinators must meet the minimum qualifications and initial and ongoing training requirements as detailed in Section 5.01, Community Options Program Guidelines.

DOCUMENTATION

1. The county agency must be able to provide documentation of support/service coordinator qualifications. If the county contracts for Support and Service Coordination services, documentation must be available regarding qualification of the contracted staff.

2. The participant record must reflect a frequency and intensity of contacts to support reported units of service and minimum contact requirements. Documentation of all contacts must reflect an allowable activity and indicate the activity's relationship to the Waiver participant's individual service plan.

3. If this service is not provided to any Waiver participant, the county agency must have the written description of how and by which providers or other natural supports the health, safety and welfare of the participant will be assured in the participant’s record along with the original and all updated individualized service plans.

4. Documentation of current caregiver and criminal background checks of all case managers must be available and easily accessed upon request. This documentation may be in either each participant's county file or the county records.

5. Each participant’s file must contain documentation that the minimum requirements have been met. If a variance from required contacts is in effect, the request and approval must be in the participant’s file.

SUPPORTED EMPLOYMENT SERVICES

SPC 615

DEFINITION

Supported Employment is the provision of assistance to facilitate the employment of a participant in an integrated work setting. Includes job development aimed at developing a position in a community job or a carved out portion of an already existing position. Participants using this service may need ongoing support to maintain employment. Specific services include vocational/ job-related assessment, job development, referral, on-the-job support and coaching, education or training and transportation. Other support services including services not specifically related to job skill training may also be provided based on the needs of the specific participant served.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. Supported employment may not be funded by the Medicaid Waiver until Vocational Rehabilitation funding is exhausted, unnecessary or unavailable.

2. Transportation may be provided by the supported employment provider and included in the rate paid to that provider or may be provided by a transportation provider and reimbursed under the service Specialized Transportation.

3. Federal and state wage certificates must cover the participant and the employer whenever the participant is paid at a rate that is less than the state's minimum wage.

4. All local, State and Federal laws governing any aspect of employment must be followed.

5. The provider must be able to demonstrate the ability and qualification to provide this service through one of the following ways:
   a. Accreditation by the Rehabilitation Accreditation Commission (CARF);
   b. Receiving accreditation by another nationally recognized accreditation agency;
   c. The existence of a current contract with the State's Vocational Rehabilitation agency (DVR) for supported employment service provision; or
   d. The submission of written documentation that evidences the organization meets all DVR Technical Specifications related to supported employment.

6. All persons providing services and supports to any Waiver participant shall be subject to a criminal and caregiver background check before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for

the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

7. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9.

8. The provider shall send a written report to the Support and Service Coordinator not less than once every 6 months. A copy of this report shall be sent to the participant or their guardian.

STANDARDS

A. PROGRAM

1. Participants must be paid wages commensurate with their productivity. The employment is expected to be integrated, stable and safe. It shall provide regular and predictable working hours, and opportunities for advancement or expansion of job duties.

2. The Supported Employment Provider agency must be able to deliver service in accordance with the Technical Specifications for Supported Employment. These specifications include the following :

a. Assessment:
The assessment is an evaluation of a participant's functional abilities in a variety of settings. The provider must involve the participant and as appropriate, the participant's family and advocates. The assessment shall document the preferences, values and needs of the individual. The assessment occurs in environments both familiar and unfamiliar to the participant. The assessment may include community work experiences. Not less than 80% of the assessment may occur in the community. Assessments must be updated as necessary. The purpose of the assessment is to determine:
(1) The participant's desire for supported employment;
(2) A participant's appropriateness for supported employment;
(3) The nature and intensity of services which may be necessary for the participant to obtain and sustain employment;
(4) The participant's strengths and abilities;
(5) The participant's employment goals;
(6) The participant's economic status and the possible loss or reduction of public benefits;
(7) The participant's relevant health information;
(8) The participant's need for assistive technology or other accommodation;
(9) The participant's preference for job development strategies;
(10) The participant's current support systems;
(11) The participant's past vocational experience, education and training; and
(12) The participant's accessibility needs; and

(13) Any safety considerations that may be needed for a supported employment placement.

b. Plan for job development
Upon completion of the assessment, the plan for job development is completed. This plan along with the assessment is sent to the county and the participant/guardian. Job placement cannot occur prior to a review of the assessment and plan for job development. The plan for job development plan must include the following elements:

(1) A description Identification of the procedures and process used to complete the assessment;
(2) A statement that describes how and to what degree the participant will control their supports;
(3) A summary of the participant's preferred days, time of day and hours per week to work;
(4) A description of any preferred industry/employer where the participant would prefer to work ;
(5) Approximate amount and type of support the participant needs on and off the job in order to sustain the employment.
(6) Identification of the amount and type of long-term support service needs of the participant;
(7) A description of the specific service to be provided in conjunction with the supported employment services and the identity of the providers and individuals that will provide each service;
(8) Identification of job development strategies that will be used;
(9) Identification of potential job sites;
(10) Identification of job training/coaching and any strategies to fade out supports; and
(11) The plan for monitoring the participant's outcomes or goals.

c. Job coaching/teaching (supported employment training)
Job coaching/teaching includes specific job skill teaching provided either on or off the job site, coordination of work related services such as transportation, providing assistive technology resources and other disability related accommodations and teaching the participant about work-related behavior and other employment standards.

B. PERSONNEL

1. Supported employment services shall be provided by personnel that have skills and abilities in the areas of assessment, job development, job placement, job retention and evaluation. Typical skill that personnel should have include:

a. Knowledge, skill and abilities in assessing individuals who have developmental disabilities including:

(1) Observational methods and techniques;
(2) Interviewing methods;
(3) Developing work experiences for situational assessments;
(4) Performing person-centered planning;
(5) General awareness of human service delivery systems and the local business community; and
(6) Awareness of best practices in supported employment.

b. Skill in work site analysis including:

(1) Identifying essential job functions;
(2) Identifying job quality standards;
(3) Identifying opportunities for job restructuring,

c. Skill in assessing needs for assistive technology, disability accommodation and individualized ergonomics.

d. Skill in the area of job development including:

(1) Job restructuring and/or position carve out;
(2) Conducting community labor market surveys;
(3) Initiating and maintaining employer contacts;
(4) Using targeted marketing approaches in job development efforts;
(5) Conducting job analysis;
(6) Matching individuals to specific jobs
(7) Following up with employers (especially after trainer fade-out) and,
(8) Facilitating job expansion or advancement.

e. Skill in the areas of sales and marketing including:

(1) Developing and presenting a proposal on behalf of an individual;
(2) Assisting an individual to present their need for accommodation;
(3) Facilitating achievement of natural support from co-workers;
(4) Marketing of supported employment;
(5) Developing and maintaining positive relationships with employers;
(6) Identifying and meeting employer expectations;
(7) Using community resources effectively;
(8) Working with teams;

(9) Communicating with staff about job market trends and training needs; and
(10) Training the community and employers on the merits of supported employment.

f. Skills in the area of job coaching including:

(1) Understanding developmental and other learning styles;
(2) Designing and implementing strategies to accomplish job retention.
(3) Understanding successful on-the-job training, including fading strategies;
(4) Understanding the value of employer consulting and,
(5) Providing employment counseling and knowing when to offer it.

g. Skill in the area of outcome development and program evaluation.

(1) Measuring personal outcomes of participants, and
(2) Implementing participant satisfaction surveys and other quality assurance, quality improvement and evaluation tools and methods.

DOCUMENTATION

1. The participant file that is maintained by the service coordinator shall contain an assessment where the need for this service must be documented

2. The participant file shall contain documentation that DVR services were either denied, exhausted or are not available before the Waiver was used to fund this service.

3. The participant's county file must contain a copy of the supported employment assessment, job development plan and all 6 month progress reports.

4. The county must document that the service provider meets all applicable standards.

5. The provider shall maintain an individual file for each participant served. This file record must include the assessment, job development plan, training/coaching plan and plan for long-term support.

6. The cost of transportation related to Supported Employment shall be separated and documented.

7. Documentation of current caregiver and criminal background checks of all service providers must be available and easily accessed upon request. This documentation may be in either the participant's county file or in the county record.

SUPPORTIVE HOME CARE

SPC 104.10 days
SPC 104.20 hours

DEFINITION

Supportive Home Care is the provision of a range of services for participants who require assistance to meet their daily living needs, ensure adequate functioning in their home and permit safe access to the-community.

Supportive home care services include:

1. Personal Services
    a. Assistance with activities of daily living such as eating, bathing, grooming, personal hygiene, dressing, exercising, transferring and ambulating;
    b. Assistance in the use of adaptive equipment, mobility and communication aids;
    c. Accompaniment of a participant to community activities;
    d. Assistance with medications that are ordinarily self-administered;
    e. Attendant care;
    f. Supervision and monitoring of participants in their homes, during transportation (if not done by the transportation provider) and in community settings;
    g. Reporting of observed changes in the participant's condition and needs; and
    h. Extension of therapy services. "Extension of therapy services" means activities by the SHC worker that assist the participant with a PT or OT treatment plan. These include assistance with exercise routines, range of motion exercises, standing by during therapies for safety reasons, having the SHC worker read the therapist's directions, helping the participant remember and follow the steps of the exercise plan or hands on assistance with equipment/devices used in the therapy routine. It does not include the actual service the therapist provides.

2. Household Services
    a. Performance of household tasks and home maintenance activities, such as meal preparation, shopping, laundry, house cleaning, simple home repairs, snow shoveling, lawn mowing and running errands;
    b. Assistance with packing and general house cleaning when a participant moves.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. The county agency shall assure that SHC providers meet the requirements of this section and have a process for accomplishing this.

2. Supportive Home Care (SHC) services excludes Daily Living Skills Training (DLST). DLST is distinguished from SHC by the intent of the provider. SHC providers perform tasks the participant is unable to do without assistance while DLST providers seek to teach the participant to do the task by his/her self.

3. Household maintenance excludes all tasks associated with additions or modifications to the physical structure of the home. Changes to the physical structure of a home may be covered under Home Modification Services.

4. Only those personal care services not reimbursable under the Medicaid State Plan may be reimbursed using Waiver funds.

5. Services provided by anyone under the age of 18 shall comply with Child Labor Laws.

6. Family members allowed to be compensated for providing SHC services are subject to these standards.

7. The value of room and board for live in providers is a permitted form of compensation and cover the value of the housing and food that can reasonably be attributed to the live-in SHC provider. Reasonable expenses shall be computed by any method generally acceptable for allocating such costs such as methods recommended by the Federal Internal Revenue Service for dividing costs in shared rental situations.

8. Participants must be given the opportunity to direct some or all of their Supportive Home Care whenever possible to the extent of their ability and desire. The county must determine the participant's ability and/or desire to direct Supportive Home Care by assessment and by observation and address this in the participant’s plan.

9. Supportive Home Care services are required to be reviewed by the county whenever there is a change in provider or a change in the individuals needs and abilities and at least once every six months if no change occurs.

10. SHC services may not duplicate services the participant receives in a licensed or certified substitute care setting.

11. County agencies shall ensure that procedures for arranging backup when a care provider is not available are in place.

12. Provider Screening Requirements: All persons who provide this service shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of these services such as misappropriation of participant funds shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual.

13. All SHC providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter 9.

STANDARDS

Supportive Home Care providers shall be trained according to the requirements of this section. The provider shall complete required training within six months of beginning employment unless training is needed before the provider can safety provide the service. This must be specified in the participant's individualized service plan.

A. Content of training - The county agency shall ensure that persons providing SHC services receive training on at least the following subjects pertaining to the individual participant (s) served:

1. Policies, procedures and expectations of the county and/or contract agency including training on the participant and provider rights and responsibilities, record keeping and reporting and other information deemed necessary and appropriate.

2. Information about the participant(s) to be served including information on participant's specific disabilities, abilities, needs, functional deficits, strengths and preferences. This training should be person specific for the people to be served and generally focused.

3. Recognizing and appropriately responding to all conditions that might adversely affect the participant's health and safety including how to respond to emergencies and Critical Incidents as defined in Chapter 9 of the Medicaid Waivers Manual.

4. Interpersonal and communications skills and appropriate attitudes for working effectively with participants. These include: understanding the principles of person-centered services, participant rights, respect for age, cultural, linguistic and ethnic differences, active listening, how to respond with emotional support and empathy; ethics in dealings with participants, family and other providers, how to handle conflicts, how to deal with death and dying and other topics relevant to the population to be served.

5. Confidentiality laws and rules.

6. Procedures for handling complaints.

7. Personal hygiene needs, preferences, and techniques for assisting with activities of daily living including, where relevant, bathing, grooming, skin care, transfer, ambulating, exercise, feeding, dressing, and use of adaptive aids and equipment.

8. Homemaking and household services, meal planning and preparation, shopping, housekeeping techniques and proper maintenance of a clean, safe and healthy living environment.

9. Personal health and wellness-related needs of the participant including nutrition, dietary needs, exercise needs and weight monitoring/control.

B. Exemptions from required training: An exemption may be granted in the following circumstances:

1. With the exception of the topics covered in numbers 3, 5 and 6 above, if the county agency or its agent judges that the provider already possesses comparable knowledge or experience or the provider's duties will not require the particular knowledge and/or skills, an exemption from training may be granted. Exemptions from training on matters relating to health, safety and welfare, confidentiality and the complaint system may not be considered. Requests for exemptions and the exemption rationale for each component of the training requirements for which an exemption is requested must be described in writing and approved by the appropriate county staff person or their agent. A copy of the exemption and rationale for granting it must be kept in the participant's record or in another accessible place and be available if requested.

2. A participant or their guardian, if functioning as the employer, may grant training exemptions under number 1 of this section. The county agency must document and maintain the rationale for such exemptions. An exemption from all training is warranted only when the individual provider already has the skills and knowledge in each of the training areas described in number 1, above.

3. An individual who is a Medicaid certified Personal Care Worker (PCW), a Home Health Aide, a Certified Nursing Assistant (CNA), a Registered Nurse (RN), or a Licensed Practical Nurse (LPN) is considered as meeting the training standard. These providers do not need a written justification for an exemption to the training requirements.

4. Persons providing only household services must receive training and orientation on:
   a. The county agency and contact people;
   b. How to provide services safely; and

5. What to do in an emergency.

C. Provider training by the participant. Waiver participants may be authorized to train providers. When the participant is authorized to do so, the decision must be in writing, must list the areas of training covered and be placed in the participant and/or the provider file.

DOCUMENTATION

1. The county agency shall document its policies and procedures regarding the application of these standards.

2. The county agency shall document the provider's qualifications and place these in the participant's file or other central location that can be easily accessed on request.

3. The need for the provider to be trained prior to the provision of the service shall be specified in the person's individualized service plan.

4. The county or contract agency is responsible for assuring that each provider has received the agreed upon training and shall maintain documentation that such requirements have been met. If exemptions to any portion of the training requirements are given, the exemption and its rationale must be in writing and a copy must be placed in the participant's file.

5. The county agency must write and retain the required documentation of the rationale for any training exemption granted by a participant or guardian acting as an employer of a SHC worker.

6. Documentary evidence of that the person is a qualified CNA, PCW, RN or LPN should be maintained in the persons file.

7. Documentation establishing the comparability credentials of Medicaid certified PCW, a CNA, a RN, or a LPN personal care workers, home health aides, registered nurses, or licensed practical nurses exempted from training must be on file in either the participant's file or in a provider file readily accessible.

8. Documentation that both types of background checks were conducted and are current.

9. The frequency, intensity and any changes in supervision provided must be documented and communicated to all SHC workers.

10. The county must document the participant's ability and/or desire to direct Supportive Home Care in the participant's plan. The plan must also address the steps taken to enhance the individual's ability to direct Supportive Home Care Services or provide documentation of the individual's inability or desire not to perform this task.

11. Documentation of current caregiver and criminal background checks of all Supportive Home care providers must be available and easily accessed upon request. This documentation may be in either each participant's county file or in county records.